

the

Canadian



Nurse



VOLUME 58

MONTREAL

NUMBER 4

APRIL, 1962

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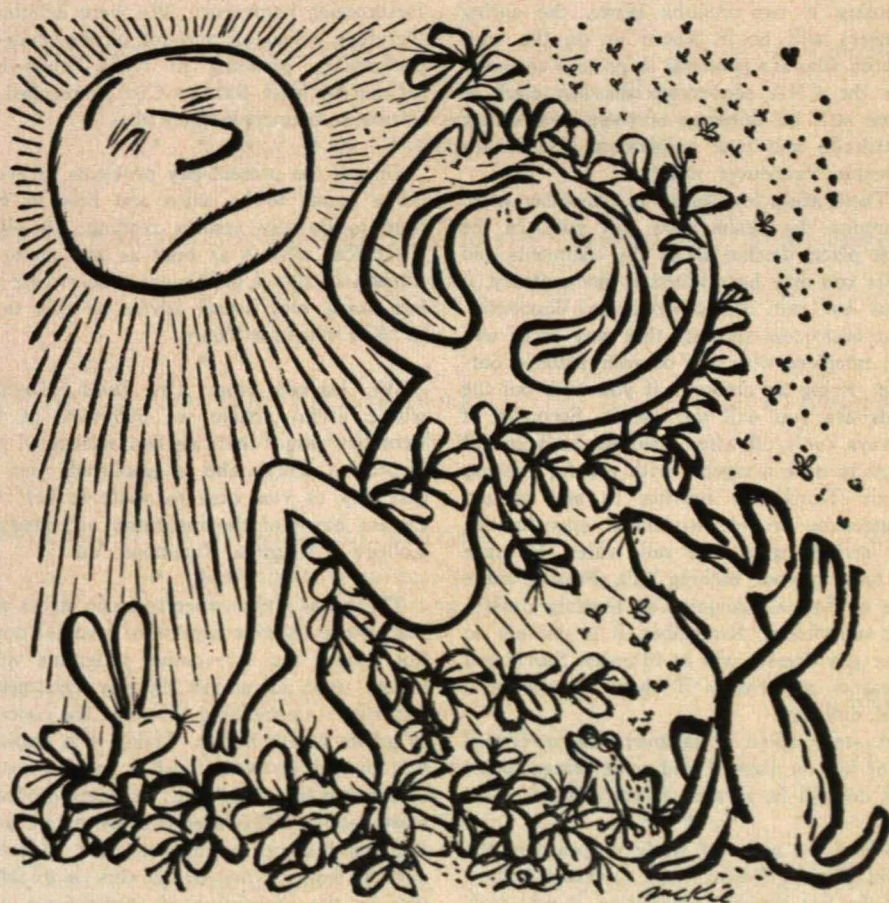


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Between Ourselves

As this column is being prepared snow is pelting down in Montreal. As you are reading it two months hence, the spring flowers will be in bloom or on the way. Those who are planning to go to Vancouver for the CNA convention the last week in June will be thinking of their new spring wardrobe and how suitable it will be for possible Vancouver weather.

There are a few things to remember when planning the clothes you will take. In the first place, despite all of the comments and jibes you may have heard to the contrary, it does *not* rain all the time in Vancouver. The occasional showers that may occur will not interfere with any of your planned outings. Bring an umbrella if you wish but the odds are you will not use it. Secondly, it always cools off after sundown so you will want to have a topcoat with you for evening wear. Third, the beaches in and around Vancouver provide wonderful opportunities for swimming in the salt water. Be sure to tuck in your bathing suit. Finally, there are no formal banquets so evening dresses are superfluous. Remember, it is summer so your gay dresses will be in order. Skirts and sweaters are handy if there should be a cool, dull day.

A story about Vancouver, the entertainment that is planned and some things to see and do will be in next month's issue.

* * *

When the areas of study proposed in the Pilot Project Report were reviewed following the last biennial convention, it was realized that the implementation of Recommendation 3 demanded the development of a whole battery of criteria. The study was to *"evaluate the quality of nursing service in the areas where students in schools of nursing receive their clinical experience."* Evaluating quality is no simple assignment. In the capable hands of Miss F. LILLIAN CAMPION, some preliminary steps have been taken as you may learn from her editorial comments in *"On Achieving Excellence."*

* * *

Our feature articles this month deal with the need for and the planning steps essential to the inauguration of an affiliation program in psychiatric nursing for student nurses. We had received a special request to publish Dr. SIDNEY M. JOURARD's article this month so that directors of nursing

and the instructors in their schools could have an opportunity to read it prior to a forthcoming conference. We were delighted, therefore, when an account of the steps of preliminary planning in New Brunswick, written by Miss RYLLYS CUTLER reached us in time to be included here also.

* * *

One of the present-day problems of every nurse seems to be when and how to find time to do any serious reading. Dr. RAE CHITTICK, who is as busy as any nurse in Canada is also a prodigious reader. She offers some very sound advice on this topic in *"The World is Yours."*

* * *

We learned from Dr. JEAN HAYTER, whose useful article we published in the February issue, that we had misnamed the institution where she is employed. Just in case any of you wish to write to her, the correct name of the institution is: Medical College of Virginia, Richmond, Va.

* * *

There was a time when so much stress was put on the curative aspects of hospital nursing service that preventive programs were looked upon as almost entirely extraneous activities — something that was the concern of public health nurses. Today it is realized that prevention is as much a part of hospital nursing care as is cure; that cure proceeds more rapidly when adequate preventive precautions become an intrinsic part of every nurse's work. Nowhere is this more true than in the prevention of contractures and decubitus ulcers. Miss OLGA D. WOLENSKI not only describes the essential procedures carefully but has provided visual instruction in how to carry them out. Separate boards for each foot makes so much better sense than relying on only one. And keeping the feet in shoes is certainly a far better way to prevent foot-drop than merely hoping.

We should not demand of life the performance of hopes and aspirations which only the passage of time will ripen.

The Royal Bank of Canada Monthly Letter, Vol. 42, No. 9.

* * *

Talent alone cannot make a writer, there must be a man behind the book. — EMERSON

THE CANADIAN NURSE

VOLUME 58

NUMBER 4

APRIL 1962

305 ON ACHIEVING EXCELLENCE.....*F. L. Campion*

Miss Campion is Director of the Project for the Evaluation of Nursing Service. She is on the staff of the Canadian Nurses' Association, Ottawa.

307 INTEGRATING MENTAL HEALTH INTO THE CURRICULUM....*S. M. Jourard*

Dr. Jourard is associate research professor at The Hillis Miller Health Center, University of Florida, Gainesville, Fla.

314 AN OLD GIRL GOES BACK TO WORK.....*V. Wellwood*

Mrs. Wellwood lives in Nelson, British Columbia.

315 PSYCHIATRIC NURSING AFFILIATION.....*R. Cutler*

Miss Cutler is assistant professor on the staff of the School of Nursing, University of New Brunswick, Fredericton.

319 THE WORLD IS YOURS.....*R. Chittick*

Dr. Chittick, who is a Past President of the Canadian Nurses' Association, is the Director of the School for Graduate Nurses, McGill University, Montreal, Que.

322 THE IMPACT OF CHANGE.....*C. Tennant*

Miss Tennant is Director of Nursing, Municipal Hospital, Lethbridge, and president of the AARN.

334 HEALTH PROBLEMS IN VARIOUS AGE GROUPS.....*D. Rowles*

Miss Rowles is an inspector in schools of nursing with the Nursing Branch, Ontario Department of Health, Toronto.

339 MEETING PATIENTS' NEEDS.....*M. Allen*

Miss Allen is associate professor of nursing, McGill University, Montreal.

348 PREVENTION OF CONTRACTURES AND DECUBITI.....*O. D. Wolenski*

Miss Wolenski is Clinical-Instructor-Supervisor, Rehabilitation Unit, University of Alberta Hospital, Edmonton, Alberta.

282 BETWEEN OURSELVES	328 NURSING PROFILES
286 PHARMACEUTICALS AND OTHER PRODUCTS	346 IN MEMORIAM
288 RANDOM COMMENTS	352 CONVENTION HIGHLIGHTS
313 MACMILLAN AWARD WINNERS	356 EMPLOYMENT OPPORTUNITIES
326 THE WORLD OF NURSING	378 EDUCATIONAL OPPORTUNITIES
	383 INDEX TO ADVERTISERS

*The views expressed in the various articles are the views of the authors and do not necessarily represent the policy or views of
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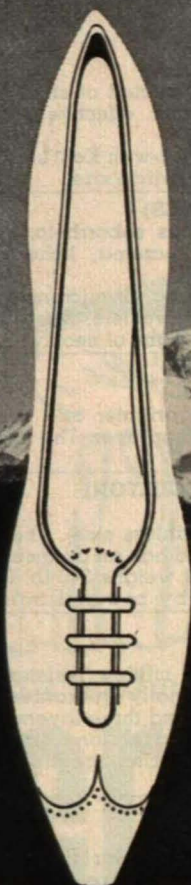
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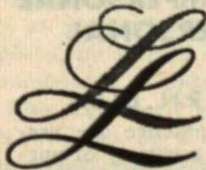


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Random Comments

Dear Editor:

I should like to avail myself of your generous offer of a free *Journal* "Index for 1961" as announced in the December issue of *The Canadian Nurse*.

I have been receiving *The Canadian Nurse* for several years, and frequently refer back to issues of previous years.

If there are still some indexes available from previous years (1955-60) I would appreciate one for each year.

LILY FISCHER, Manitoba

Dear Editor:

Previously, I had been a subscriber to *The Canadian Nurse* while at home in Nova Scotia and more recently here in the U.S.A.

I wish to renew my subscription as I read many of my old copies with great interest. Also, many of the American nurses seek copies of it from me.

MARINA BEST, Cincinnati, Ohio

Dear Editor:

I have been receiving *The Canadian Nurse* ever since I graduated in 1951 and have enjoyed reading the many articles. They have been a great help to me in my work. I especially appreciated the *Journal* when I was attending the University of Saskatchewan last year.

Would it be possible to obtain previous indexes as well as self-binders. I would like to sort my copies for easy reference.

AGATHA WAHL, Manitoba

¶Self-binders are available from the *Journal* office, price \$3.00 each. Ed.

Dear Editor:

One of my nurses drew my attention to the article "Prenatal Care" by Dr. Victor D. McLaughlin that appeared in the December, 1961, edition of *The Canadian Nurse*.

There are certain statements in this article which seem to be not in accordance with modern medical thinking and teaching.

1. Dr. McLaughlin states: "Iron intake is a real problem for all mothers, however. The normal menstruating young woman just barely keeps herself in iron balance. What she takes in during a month in her ordinary diet is just equal to what she loses in her menstrual flow. Pregnancy presents her with a demand for iron approximately tenfold that



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of menstruation, that is, ten times what she would lose during menstruation for ten months, not just one month. Therefore, every woman should have an increased intake of iron during pregnancy. To do this through diet alone is difficult. Most patients can afford one of the less expensive multivitamin and mineral preparations."

According to most modern text books the average loss of iron due to a menstrual period is 35 to 50 mg. (in many cases this is much higher), and since the fetus requires about 2.5 to 2.7 mg. of iron per day it is difficult to see why a pregnant woman should require ten times the amount of iron lost during menstruation. During pregnancy the absorption of iron is greatly increased and many authorities believe that the average healthy woman does not require any additional iron during pregnancy. Obviously, the answer to this problem is a hemoglobin estimation — taking into account that during pregnancy hemodilution occurs and a reading of 10 to 12 gm. of hemoglobin could be regarded as normal. The unnecessary routine administration of iron, especially during the early months of pregnancy should be discouraged, because it often causes gastric upsets and in any case the fetus requires very little iron during this period.

2. Dr. McLaughlin states: "The facts remain that early tuberculosis can be detected only by X-ray." As far as I am aware early tuberculosis lesions do not always show up in routine X-ray and routine chest X-ray of pregnant women may or may not be a good practice. In any case it is so much easier, more valuable and much more economical

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K. ADLER, M.B., D.P.H., Medical Officer of Health, Chinook Health Unit. Fort Macleod, Alberta.

¶ In an attempt to clarify the differences of opinion, we worked out the average requirements of a pregnant woman for iron. If a fetus requires 2.7 mg. daily then it requires 718.2 mg. for a 266-day uterine life. If the average adult requires 15 mg. per day (Musser and Bird, *Modern Pharmacology and Therapeutics*) then the mother requires 3990 mg. for a 266-day pregnancy. The total is 4708 mg. According to Dr. McLaughlin the pregnant woman's need for iron is ten-



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tion for ten months. If she loses 50 mg.
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According to these calculations the esti-
mations are very close. Ed.



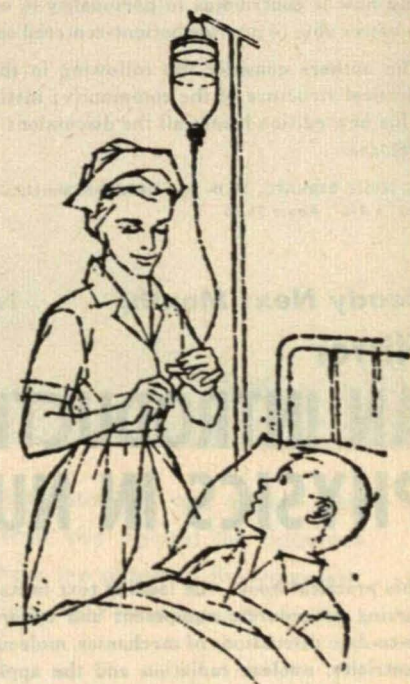
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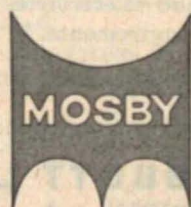
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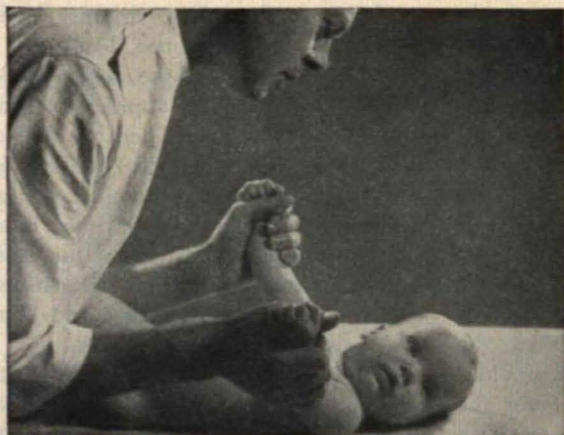
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CLINICAL REPORT

SUBJECT: On a Specific Benefit of Meat in the Infant Diet

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Excerpt from "Meat in the Diet of Premature Infants,"
Sisson & Whalen, A.M.A. Journal of Diseases of
Children, Vol. 95, Pg. 635. 1958. Available on request.



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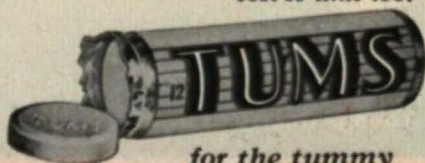


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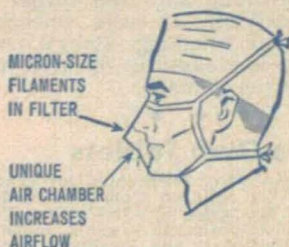
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ON ACHIEVING EXCELLENCE

BY ACCEPTING the third recommendation of the Pilot Project for the Evaluation of Schools of Nursing, the general membership of the Canadian Nurses' Association authorized the Executive Committee to proceed with a plan for the evaluation of the quality of nursing service.

Evaluation. Quality. These words express or imply measurement and a degree of excellence. Thus, the Canadian Nurses' Association is committed to a project to measure the degree of excellence of nursing service in Canada.

What is excellence in nursing? By what criteria, by what methods, does one measure this? Excellence will mean different things to different people — nurses, doctors, patients, families, administrators. Each will have different expectations with regard to the quality of nursing service which they consider excellent. Some, no doubt, would stress sensitivity to patients' feelings and responsiveness to their needs, the kindness and warmth which the nurse displays to patients, or perhaps her skill in relieving distressing symptoms.

Others might consider more important the degree of technical competence and manual dexterity with which she performs her tasks, or her efficiency in organizing her work, the economy of time and effort she displays. To others, the ability to observe skilfully, intelligently, early signs and symptoms of significant reactions to treatments



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and medications, of developing complications or the worsening of the patient's condition and to exercise good judgment in initiating prompt and appropriate action, will seem the important aspects of excellence. Some, no doubt, would prize the nurse's skill and ability in teaching the patient and his family about his illness and health, so that the patient will be assisted to help himself, and the family to understand and help the patient. The flexibility and adaptability of the nurse in adjusting routines and procedures to meet individual patients' needs, her creativity in devising new ways to meet special needs, will seem important to others in distinguishing excellence.

These, and many other aspects of goodness in nursing, will need to be carefully considered in establishing criteria for the evaluation of quality. This will be the first major task of the project — to establish criteria. The next step will be the identification of the significant indications or critical indices for which one will look to learn if the established criteria are being met. The number and type of surveys, the methods to be used and the tools required have yet to be planned.

The important function of a professional association is to give leadership, to point towards desirable goals and to indicate the means whereby these goals may be reached . . . It is an accepted principle that one's goals should always be somewhat in advance of accomplishment; for it to be otherwise would result in stagnation.²

The Canadian Nurses' Association, in undertaking this project, is fulfilling its stated responsibility to establish desirable goals that are in advance of our present accomplishments, and to indicate means whereby these goals may be achieved.

However, the entire responsibility for achieving excellence in nursing does not rest entirely with the organized profession. The health agencies and institutions providing nursing service and the employers of nurses have also a responsibility for setting

desirable goals and for seeking ways and means of achieving them. The criteria and methods established by the organized profession should be such that they will serve as guides to others, but each agency has the responsibility to state its own objectives — its own desired level of excellence — and to establish such policies and procedures as will promote a high quality of nursing service. The quality of administration must be such that the attainment of a high level of nursing care is facilitated. A careful selection of well qualified nurses for leadership positions, those possessing the qualities necessary to both conceive and achieve excellence, is important.

However, the degree of excellence achieved will depend, in a large measure, upon each individual nurse. As a professional person, the nurse has the responsibility to set her own goals high, to strive to achieve them, and to evaluate her own performance in the light of these goals. The ultimate responsibility for growth and learning rests with the individual. The degree of excellence she obtains will depend not only on her knowledge and understanding, or her skills, but on the kind of person she is. To quote Gardner³,

I am not saying that we can expect every man to be excellent, it would please me if this were possible . . . those who achieve excellence will be few at best. All too many lack the qualities of mind or spirit which would allow them to conceive excellence as a goal or to achieve it if they conceive it.

But many more can try to achieve it than now do. *And the society is bettered not only by those who achieve it but by those who are trying.*

F. LILLIAN CAMPION, M.A.

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Integrating Mental Health into the Curriculum

SIDNEY M. JOURARD, PH.D.

How well do you listen to your patients? How effectively do you use the information that they give you, directly or indirectly?

Integrating Concepts

EDUCATORS in the health professions have recently become very concerned about "integrating" concepts from the disciplines of psychology, sociology, anthropology, and psychiatry into their basic curricula, presumably with a view toward improving the quality of professional practice. Doubtless this concern is an outgrowth of discontent, on the part of professional people and clients alike, with the often impersonal nature of professional care. In medicine and nursing there is a further reason for concern with "integration." I refer here to the increasing conviction, based on the experience of psychotherapists, that a patient's "self," and the nature of the physician-patient and nurse-patient *relationship* are factors in the patient's illness and recovery.

When we look afresh at the unwieldy jargon of the "integration" assignment, (professional educators seems to be no different from other disciplines in their predilection for untranslatable technical terms!), we are impelled to inquire, "What is a mental health concept? A psychiatric concept? How does one go about 'integrating' these things? How can anyone tell when 'integration' has been accomplished?"

In my work I have studied questions inherent in the problem of "integrating mental health and psychiatric concepts." As a result I have arrived at a direction of thinking which seems to hold some promise of answering these questions in a workable and feasible way. I sought to look at the professional person-client relationship from a viewpoint sufficiently detached to enable me to identify pertinent variables in the helping transaction.¹ Then I tried to determine just what it was that the educators wanted from "mental health" disciplines — mainly psy-

chiatry and psychology — and what actually could be offered to them. The present paper is an attempt to outline a working conception of what mental health disciplines have to offer medicine and nursing, together with some suggestions regarding the manner and manifestations of their "integration."

Physiological Concepts

Man can readily be "dissected," both conceptually and literally, into a number of component systems, for example, his circulatory system, endocrine system, nervous system, excretory system. Students of these "systems" — specialists — provide the beginning or the general practitioner with knowledge of the range within which the respective organs and their functions vary in wellness and disease. The practitioner is then able, with a given patient, to observe and measure these systems by employing his observations for the diagnosis of illness, and as criteria for progress in treatment. The non-specializing practitioner does not know all there is to know about each system, but he doesn't have to. He does know, however, that his job calls for him to be acquainted with some knowledge of the body systems, and he conscientiously applies it when he is observing any patient. Routinely, most physicians will check a patient's pulse and temperature because it has been learned that the behavior of the heart and the body temperature are sensitive indices of the degree of wellness of the entire body. Attention to these phenomena doubtless illustrates the successful "integration of physiological concepts into medical education and practice."

The Phenomenal Field

Psychological science has addressed itself to the systematic study of man's inner experience and his overt be-

havior. These comprise his *dependent* variables. Their dependence upon myriad pertinent *independent* variables can be investigated. Behavioristic psychologists limit themselves primarily to the analysis of the *stimulus* control of behavior, but their findings have had little to offer a clinical practitioner. The "phenomenological" psychologists — those concerned with man's subjective side, that is, with his "self," his inner experience, have shown convincingly that man responds, not to stimuli *per se*, but rather to the *meanings* that stimuli have for him. They have introduced the concept of the *phenomenal field* to describe the sum total of a man's conscious experience at any given moment. This field includes an individual's perceptions, beliefs, imaginings and memories. It also includes a system of cognitions called the *self-structure*.² This latter term refers to the beliefs, feelings and ideals that an individual holds with regard to his own personality. I would like to propose that this complex perceptual-cognitive system — the phenomenal field — is the *variable* which, when "integrated" into medical and nursing curricula and practice, will bring about the outcomes that educators have sought — more personalized care of patients, more apt diagnoses, and more effective therapy. While much of what follows may seem banal and obvious, the explicit statement of the "obvious" has value, if for no other reason than to permit critical assessment. Furthermore, the manner in which the exposition develops throws light on the ways in which "integration" might be accomplished.

It has been asserted that man's phenomenal field is a crucial variable in man's behavior. This clearly implies that, to understand man's overt behavior, *we must become acquainted with the contents of his phenomenal field*. We are obliged to learn what he is thinking and feeling, and what the things in the world mean to him. It is also pertinent to assert that *man's phenomenal field affects and is affected by the functioning of the various anatomical and physiological systems*. Circulation, respiration, blood chemistry, and so forth are known to vary with the emotional state of man.

Thus, if a man's behavior and over-

all physical condition are to be fully understood, we must pay due attention to his phenomenal field. This raises the question, "How does one get to know a person's phenomenal field?" If we regard the phenomenal field as a species of gauge, or recording instrument, we can ask, "How does a practitioner make the readings?"

Self-disclosure

It is possible to guess at a man's probable inner experience — this is what empathy entails — but guessing is rather unreliable. A more direct, perhaps the most direct means, of obtaining "readings" from a man's phenomenal field is to encourage and permit him to disclose in words and gestures what he is experiencing; what he sees, feels, believes, remembers. A person's *self-disclosures*,³ constitute the equivalent of the numbers on a thermometer. They are his attempt to communicate to the doctor or nurse just how the world and his body seem to him. There is reason to suspect that the phenomenal field is an even more sensitive indicator or gauge of the person's condition than, for example, the pulse rate. Anyone who is able to count can take a pulse reading. Anyone who can hear can take a phenomenal-field "reading." But all data, whether tracings from an EKG, numbers from a manometer, or the self-disclosures of a patient, call for recording and interpretation before they can be employed helpfully in diagnosis and assessment of progress in therapeutic treatment. Anyone who can write can make entries in a medical record. It takes training and sophistication to be able to "make sense" of the entries that have been made.

With respect to employing phenomenal-field "readings" in medical and nursing practice, two problems arise:

(a) How to encourage and permit a patient to disclose his inner experience fully, spontaneously, and truthfully, and (b) how to interpret what has been disclosed. Scientific students of interpersonal behavior and man's self-structure have some pertinent answers. Broadly speaking, a person will disclose himself to an interested audience who is warm, permissive and concerned.⁴ Skill in eliciting and reinforcing self-disclosure can be learn-

ed. It is already being taught in college courses in interviewing techniques. Witness the increasingly widespread use of the "reflection" technique. Skill in *interpreting the meaning* (manifest and latent) of disclosures, both verbal and non-verbal, can be learned, but it calls for extensive grounding in various basic disciplines, for example, sociology, psychoanalysis, personality theory.

Every person has the capacity to disclose the contents of his phenomenal field on request, unless these contents conflict with his self-concept, his public self, or his conscience.⁵ Under the latter conditions, disclosure may be highly threatening. The person may refuse to disclose himself openly, honestly and spontaneously. In very general terms, we may say that *anxiety* makes a person reluctant to reveal the contents of his phenomenal field to someone else. This implies that a professional person, such as a nurse, teacher, physician, or psychotherapist must learn ways of recognizing and coping with the anxieties that inhibit self-disclosure.⁶ However, in our culture, people withhold self-disclosure for another, more obvious reason. They believe (often erroneously) that no one is interested in *their* unique view of the world, *their* thoughts and feelings. Consequently they keep this information to themselves, disclosing only banalities and clichés.⁷ If a nurse or teacher conveys a sincere interest in learning what is on the mind of the patient or student, then this reason for avoiding fuller disclosure can easily be by-passed.

The Psychological Gauge

It is the thesis of the present paper that "mental health and psychiatric concepts" will have been integrated into the curriculum and practice of health professions when "readings" from the psychological "gauge" — self-disclosures from the patient — are as routinely obtained, recorded, evaluated, and acted upon as are readings of temperature or blood pressure, or observations of dressings. We have already suggested that the routine interest of the physician in determining pulse, blood count, urine content, and so forth indicates the "integration of *physiological* concepts into medical

curricula and practice." Observations of the pulse, the blood, and the urine are made because it is known that these factors vary with the over-all condition of the body. Such observations facilitate diagnosis and treatment. If there is one single concept or contribution that psychological science has made to applied fields such as medicine, nursing or education, it is this: *Man's phenomenal field, including his self-structure, is a variable related both to behavior and to physiology.*

The content of a man's phenomenal field is a sensitive indicator of his total organismic state — either well or ill — just as is the pulse, skin temperature or blood chemistry. It may be accepted as a truism that the phenomenal field is a variable of crucial significance to medicine, nursing, and all other fields in which one person is striving to promote change of some sort in another. *When the phenomenal field is not "checked" routinely in nursing or medicine, a crime of omission is committed, the gravity of which is no less serious than failure to make routine physiological checks.* A patient's phenomenal field constitutes information that may be highly crucial in arriving at a diagnosis or in planning therapy. This information is not only pertinent at the time when a "history" is being taken. The phenomenal field goes on registering thoughts, feelings, fantasies, memories and perceptions, even when a patient is asleep. In this regard, it is little different from the heart which continues to beat 24 hours daily and which is routinely checked every time a physician encounters a patient.

When a professional person of any sort is face to face with his client, he is maximally helpful when he refreshes his concept of the client's condition.⁸ This means making all pertinent observations. There is little basis for assuming that the patient is exactly the same from hour to hour. Fresh observations are called for with every contact. The information obtained from a patient's disclosures can be evaluated in its own right, or correlated with other data that are available, for example, physiological measures of one kind or another. Thus, in response to the question "How do you feel?" a patient may say, "I feel just

fine" — then one finds his pulse racing, his blood pressure high. Discrepancies of this sort (not unlike a primitive lie detector) will mean something to the physician or nurse responsible for the patient's well-being.

We have mentioned several times that obtaining self-disclosure from a patient is a direct analogy to obtaining data about a patient's blood pressure. The phenomenal field and the sphygmomanometer are both "gauges" which register data of importance to the practitioner. There is one crucial difference between the processes of obtaining a blood pressure reading and a phenomenal-self "reading" that must be noted.

Using the Information

Few patients report an increase in well-being following a blood pressure reading. Many patients, however, will experience a reduction in anxiety and physical tension, and an increase in their feeling of their own identity and worth, following the experience of full self-disclosure to an interested nurse or physician. As Freud noted, the technique of observation and the mechanism of helping are well-nigh identical in psychotherapy in particular, and in interpersonal transactions in general.

What does one do with "readings from the psychological gauge" — a patient's self-disclosure? For that matter, what does a nurse or physician do with blood pressure and pulse readings? These data are recorded on special charts; they are plotted; most important, they are used as the basis for evaluating the over-all condition of the patient, his progress in therapy, and as guides to further therapeutic measures. I would judge that up to the present self-disclosure data has not been as systematically sought, recorded, charted, and evaluated from day-to-day, as have temperature or blood pressure, nor has it been as systematically employed as a means of assessing progress in therapy or as a guide to therapeutic measures — except perhaps accidentally.

Suppose I were a physician, glancing over a patient's chart. Under the heading "temperature," I would note the daily fluctuations. Under the heading "bowel movements," I might no-

tice that these had been carefully recorded. Under the heading "patient's self" I might notice *nothing*. This should mean something to me. Or I might notice six brief entries made for Mr. Jones who is awaiting an operation for cancer of the rectum:

6:30 a.m. — Mr. Jones said that he feels fine.

9:00 a.m. — As he was receiving an injection, he said "I feel fine."

12:00 noon — Patient reports that he feels just fine.

7:30 p.m. — He says that he feels fine.

9:00 p.m. — He says he feels fine.

I might look at what has been entered, and wonder why he says he feels fine. I don't know what conclusion I might come to, but noting this data would impel me to make further observations. It could be that the entries (or lack of entries) for "patient's self" might reflect nothing more than the fact that no one has systematically shown an interest in making these "readings." Or, the trivial nature of the entries may show (to a skilled person) the presence of profound anxiety that has not been medically acknowledged and coped with satisfactorily. Or, the lack of entries may betoken grave neglect of important observations on the part of attending personnel.

Professional Relationships

This leads to an observation about relationships between professional people. Just as a patient may fear to disclose himself to a nurse or physician, so might the nurse dread disclosing or reporting — in person or on paper — what she has observed, felt, guessed or thought, in connection with the patient. She may fear being criticized or ridiculed. If such is the case, it could well happen that much valuable information is lost to the physician because he has not heard or read about these observations and hunches.

Just as a patient must disclose his "real self" to his doctors and nurses, so that they can be maximally helpful in diagnosis and treatment, so must all who attend the patient disclose the pertinent aspects of their experience with the patient to responsible parties. Just as a patient's phenomenal field is a most important instrument for re-

cording and reporting what goes on in his whole life-situation, so is the phenomenal field of the nurse a recording and reporting instrument — often a most sensitive one. *Any factor which inhibits disclosure of self on the part of one professional person to another is detrimental to the over-all program of diagnosis and therapy for the patient.*

Inhibiting Factors

Let it be taken as proven with face validity, that observations of a patient's phenomenal field, secured by focused interview, or through the promotion of self-disclosure while other aspects of care are carried on, is a necessary condition for optimum care and evidence of the extent of integration of mental health and psychiatric concepts into general nursing and medical care. It is pertinent to ask now, "What factors militate against obtaining self-disclosure from patients?" Perhaps the most general answers to this question are:

- a. Failure of professional people to recognize the importance of phenomenal field data in an over-all program of diagnosis and treatment;
- b. Dread of "becoming too involved" with patients when the latter are permitted to disclose themselves to a full extent.

This dread of becoming overly involved has two justifications that doctors and nurses often mention. One is that "there is too much work to be done, and so time cannot be wasted just talking or listening to patients." The other, possibly deeper reason for blocking self-disclosure in patients is *fear of the feelings which patients' disclosures can evoke in the professional person.*

Doctors and nurses often acquire the view that "to be professional" means to be without feeling in the face of human misery. Granted, it is of the utmost importance that a physician or nurse should not explode into helpless tears or impotent rage when operations are to be performed, or difficult diagnoses are to be obtained. But this is not to say that they must be impersonal machines without feelings, and without the capacity to be affected by the needs and feelings of patients. The "bedside manner," with its false jollity, or assumed omniscience, omnipo-

tence, and imperturbability is more than likely a special case of what psychoanalysts call "character armor"¹⁰ or "a magic cloak,"¹¹ donned by nurses and physicians to inhibit their own feelings, and to squelch real-self-disclosure in patients. There is ample reason to assume that competent professional work can be done by people who retain access to their true feelings. There is equally good reason to suspect that the bedside manner, far from facilitating competent medical and nursing care, actually hamstrings such care by producing an unproductive relationship between the professional person and the patient.¹² A patient who feels reassured by his doctor's and nurse's omniscience in the acute stages of his illness may feel revolted later on, when the professional person enters the sick-room, saying "Well, how are *we* feeling this morning? Did you take your pink medicine? Now, don't ask any questions, doctor knows best." Granted, this is a caricature, but transactions similar to the caricature have been known to occur in the past.

With respect to failure to recognize the importance of phenomenal field data for on-going diagnosis and therapy, professional schools may be responsible for this by important omissions in their curricula. If the curricular job had been done well, practising nurses or physicians would *feel guilty* if they did not notice and record pertinent aspects of patients' disclosures, just as they presently feel guilty of oversight if they fail to record pulse, blood pressure, laboratory reports, and so forth.

Assessing Integration

The foregoing considerations provide us with a convenient and valid basis for assessing the extent to which any health profession has effectively integrated mental health and psychiatric concepts into its curriculum. We can look for the following evidence:

1. To what extent does the professional person strive to learn each patient's "self," or phenomenal field?
2. How effective is the professional person in promoting full and pertinent disclosure of self in patients?
3. How sophisticated is the professional in interpreting or evaluating a pa-

tient's disclosure (or lack thereof) as a basis for helpful action, or as an occasion for seeking consultative help with a patient?

4. What allowance is made for disclosure data in present patients' charts? What is the nature of the entries which are made concerning patient disclosures, if any?

5. How alert is the professional person to evidence of anxiety in patients which is not obvious from the verbatim transcript of his conversation?

6. How able are doctors, nurses, and other personnel to behave at a "real-self" level with each other, and with patients, avoiding the phony nature of the bedside manner, and the constipated communication of subordinate to superior?

7. How competent are personnel in establishing and maintaining personal contact with the reality of the selves of patients who come from a diversity of age ranges and cultural backgrounds; who suffer a variety of physical ills; who represent diverse personality structures?

The Curriculum

Direct acknowledgment of the importance of patients' phenomenal fields as a factor in their illness and recovery forcefully directs the attention of educators to aspects of their curricula which enhance or inhibit students' ability to obtain, and cope helpfully with self-disclosure in patients. "Interpersonal skill" or "interpersonal competence" then acquires more explicit meaning. In this context, it implies ability to facilitate disclosure in patients; to acknowledge and interpret what has been disclosed; to use the information as the basis for more accurately "aimed" professional action. Such action may run the gamut from brief psychotherapy, to a factual lecture, to frank admission of inability to cope with the facts that have been learned. On those occasions, the professional person may then call for help from suitable specialists.

Acknowledgment of the importance of patients' phenomenal fields does not necessarily imply that all nurses, physicians, or aides must be fully trained psychotherapists. Psychotherapy is a specialty which seeks to change personality in basic ways. It calls for special training. However, every practitioner can be trained to recognize

the importance of observation of patients' inner experiences. Every practitioner can be helped to improve in skill at eliciting the necessary self-disclosure. The improvement of over-all medical care will be assured if all personnel — nurses, physicians, aides — routinely seek and record disclosures of patients. Such a practice will have a double benefit. Not only will it ensure that crucial information is noted and reported, but it will also do much to vitiate the well-founded complaint of many patients that they are impersonally treated and thus strike positively at one source of the latent hostility¹³ which the lay public holds for medicine and nursing.

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1. See Lippit, R., Watson, Jeanne, & Westley, G., *The Dynamics of planned change*, New York: Harcourt, Brace, 1958, for a meticulous analysis of the general problem of assisting a client — an institution or an entire social institution — to change in desired directions.

2. See SnYgg, D. & Combs, A., *Individual behavior*. New York: Harper, 1949, for a systematic exposition of a phenomenological psychology which can be developed from direct study of the phenomenal field. See Jourard, S. M. *Personal adjustment*, New York: Macmillan, 1958, Ch. 9, for a discussion of the self-structure.

3. Pertinent research papers concerned with self-disclosure include: Jourard, S. M. & Lasakow, P. Some factors in self-disclosure. *J. Abnorm. soc. Psychol.*, 1958, 56: 91-98; Jourard, S. M. Self-disclosure and other cathexis. *J. Abnorm. soc. Psychol.*, 1959, 59: 428-431. See also Jourard, S. M., Healthy personality and self-disclosure. *Mental Hygiene*, 1959, 43: 499-507.

4. Carl Rogers has recently summarized pertinent research bearing on the problem of evoking maximum self-disclosure from people. See Rogers, C. R. The characteristics of a helping relationship. *Personnel & Guidance J.*, 1958 (Sept.)

5. See Jourard (*op. cit.*) for fuller explanation of these terms.

6. Harry Stack Sullivan's writings are excellent sources to consult in this connection. See Sullivan, H. S., *The psychiatric interview*. New York: Norton, 1954.

7. Somehow, our culture makes it difficult for people to acknowledge and disclose to self and others the real nature of their inner experience. Norman Vincent Peale and Dale Carnegie both have taught millions how *not* to engage in real-self-being or real-self-disclosure.

8. David Stewart speaks in this connection of the "good-will." See Stewart, D. A. *Preface to empathy*. New York: Philosophical Library, 1956, pp. 22-41.

9. See Jourard, *op. cit.* note 2, pp. 182-195 for a discussion of some factors which militate against obtaining an ac-

curate concept of another person.

10. Cf. Reich, W. *Character analysis*. New York: Orgone Institute Press, 1948.

11. Cf. Moloney, J. C. *The magic cloak. A contribution to the psychology of authoritarianism*. Wakefield, Mass.: Montrose Press, 1949.

12. See Jourard, S. M. Comments on the bedside manner in nursing. *AJN*, January 1959.

13. See Look Magazine, Feb., 1959, for an example of some reactions of the public to the health professions which betoken manifest, not latent hostility.

MACMILLAN AWARD WINNERS

The number of comprehensive nursing care studies, submitted by student nurses during 1961, was the largest we have received since the Macmillan Award Competition was inaugurated in 1954. Cash prizes of \$25.00 each have been awarded to the two competitors who earned the highest marks. Their articles will be published in the near future.

As space is available, the eight studies given Honorable Mention will also be published. Each of these students has been awarded a valuable book prize by the Macmillan Company of Canada Limited, 70 bond Street, Toronto.

Congratulations are extended to the following student nurses. Their schools of nursing and the titles of their studies are indicated. Special congratulations are in order to the instructors at the Royal Columbian Hospital, New Westminster, B.C. and the Edmonton General Hospital.

Cash Prizes

1. Stephanie Semko — Royal Columbian Hospital, New Westminster, B.C.
"Bulbar Poliomyelitis"
2. Shirley Piche — Edmonton General Hospital, Edmonton, Alta.

"Thrombophlebitis"

Honorable Mention

1. Joan Finch — Royal Columbian Hospital, New Westminster, B.C.
"Pneumonia"
2. Rosemary Broemling — Edmonton General Hospital, Edmonton, Alta.
"Diabetes Mellitus"
3. Joan Taylor — Brockville General Hospital, Brockville, Ontario.
"Spondylolisthesis"
4. Elizabeth Osborne — Kingston General Hospital, Kingston, Ontario.
"Transventricular Valvulotomy"
5. Diane Sangster — St. Boniface Hospital, St. Boniface, Manitoba.
"Hiatus Hernia"
6. Diane Davidson — Calgary General Hospital, Calgary, Alberta.
"The Scooter Accident" (Orthopedics)
7. Susan M. Miall and Diane E. Milligan — Ottawa Civic Hospital, Ottawa, Ontario.
"Agenesis of the Female Reproductive System"
8. Anne Langlois — Holy Cross Hospital, Calgary, Alberta.
"Burns"

The Ontario Conference of Catholic Hospitals is sponsoring an Institute on Nursing Service Supervision May 2-4, 1962 at St. Joseph's Hospital, Sudbury. The institute will be conducted by Misses V. C. Bredenberg and M. I. Hogan of the Catholic Hospital Association, St. Louis, Mo.

The program includes: framework of the

department of nursing service administration; role and functions of supervisor and head nurse; fundamentals of supervision; tools and techniques; development of supervisory personnel; problem-solving sessions.

The registration fee is \$10.00. Applications should be sent to Sister St. Louis, Sudbury General Hospital immediately.

An Old Girl Goes Back to Work

VIDA WELLWOOD

It all began in 1957 at the Fiftieth Reunion of the Alumnae of Royal Inland Hospital, Kamloops, B.C.

IT WAS 18 years since I had graduated. I felt young and gay again in the company of my former classmates. We trooped into the church hall for the gala tea that first afternoon and came upon the dazzling young graduates of that year seated in a semicircular receiving line just inside the door. I congratulated the first young hopeful, inwardly glad that I did not have to decide as she did where to go from here, when she spoke.

"What year did you graduate, Mrs. Wellwood?"

"1939," I bragged, still feeling young and gay and that I had accomplished a lot in the intervening years.

In a sympathetic voice she replied, "You had better sit down. Wouldn't you like my chair?"

Now, with the advent of Home Nursing Services in many areas in B.C., I have been asked to go back to work. Work? 'Tis sheer pleasure to one accustomed to loving and caring for a husband and four children, and pinch-hitting as a hired man on a rocky fruit farm in the interior of the province!

The night before my first weekend on call, the "black bag" haunted my dreams. Would I remember my bedside technique? I found that things had changed. What the cake mix is to the housewife, the bottled enema is to the health nurse! Four ounces of fluid in a plastic disposable container is "more efficient, not painful to retain, so much better than the old S.S.E." What a boon to the profession are the disposable plastic gloves for dirty dressings, impactions, etc. — a far cry from preparing and washing vaseline rubber gloves! However, in the Manual I see that head lice are still called pediculi — *something* is still the same!

At a public health institute on rehabilitation last fall great stress was placed on *not* doing things for the patient. The brace, the footboard and the sand bag have taken the place of

pillows and relaxed comfort for the patient. Active and passive movement and muscle tone were defined, with passive movement relegated to the Dark Ages. Instead, emphasis was placed on the patient's range of motion, on making the most of it and keeping the patient mobile if possible.

I find my patients are mostly older people who have to have injections, bladder irrigations, tub or bed baths. One dear old English boy (in his 80's) who has a weekly tub bath, says he has one eye, one ear, one leg, and a "wonky" heart, but I find that he has one other characteristic, common to many older folk — a sense of humor. Yesterday he said he had thought of a lovely name for his three nurses — the Bathing Beauties! His wife, like Queen Victoria, was not amused! In the first place, she said, "they are not 'Bathing Beauties' but 'Bawthing Beauties'." In the second place, she wouldn't call any one of us a Beauty! So now we know! She bought him some new undershorts when the weekend baths started. He says they are immoral. They have a drooley wolf and the caption, "Old Wolves never die, they just pant away!" imprinted on them.

Though the Home Nursing Service was not meant as an emergency service, I find that I am called for anything from the lack of circulation in the taped thumbs of a little thumb-sucker to the more urgent stroke and heart attack cases. Lately, I have had a rash of calls for free medical advice. First there was Mother Noakes, "Should I put hot or cold on my sprained ankle?" I said to exercise it as much as possible to avoid stiffness and, in between walks, to elevate it and apply an ice bag. She telephoned the next day to tell me that she had wrung out hot cloths all afternoon, that her ankle was much better and "thank you so much for telling me what to do?" Then at 11:00 P.M. (I was in bed) the phone

(Continued on page 354)

Psychiatric Nursing Affiliation

RYLLYS CUTLER, B.N.

In December, 1961 directors of nursing and faculty members from schools of nursing in New Brunswick met to discuss the question of psychiatric affiliation and their responsibility in regard to it.

THE FIRST REPORT of the Expert Committee on Psychiatric Nursing, World Health Organization, states:

The provision of a nurse with psychiatric training on the staff of a general hospital has a twofold purpose:

- a. To assist the general nurse to become aware of, and sensitive to, the emotional difficulties of patients and of how she can be of use in their solution. These include the everyday problems that illness places on the patient, as well as specific problems which arise in "critical situations" such as those due to pending surgery, mass deformity or defacement, death. These situations are of significance not only to the patient but to his family.
- b. To be of direct assistance to the general nurse in her own feelings that arise as a result of her work with other staff as well as with patients — for example, the identification and resolution of interpersonal problems among staff that give rise to tension and low morale.*

The incorporation of principles and concepts of mental health and psychiatry throughout the undergraduate program is a must if the above statements are to be meaningful. This is the joint responsibility of the home school and the affiliation agency.

One Province's Solution

The school of nursing of the Provincial Hospital, Lancaster, N.B. announced its willingness to offer an eight-week affiliation in psychiatric nursing to students in the various schools of nursing of the province. In September 1961, the directors of nursing and their instructors met with the director of nursing of the Provincial Hospital and her faculty to discuss

the proposed affiliation. It was suggested that a three-day workshop for instructors from the general hospitals should be held at the Provincial Hospital in preparation for this change in their educational programs. The content of the workshop was as outlined below:

The Purpose

- a. To assist instructors, in their home schools, to prepare students for psychiatric affiliation.
- b. To assist instructors with the subsequent follow-up of students and their application of psychiatric nursing principles and concepts to all patient care.
- c. To establish areas of responsibility for home schools and the affiliation school.

The Method

- a. *Lectures:* The majority of instructors attending the workshop had no background in psychiatric nursing; therefore, a certain amount of content was necessary.
- b. *Group Discussions:* The groups were comprised of instructors from the same school since some schools sent 4-6 members of their faculty.

Where there were only one or two instructors from a school they worked with other instructors from schools of similar enrollment.

- c. *Clinical Experience:* Three selected periods for experience on wards which students would be assigned to during their affiliation were arranged.

- d. *Audio-visual Aids:* Films, pamphlets and books which would be of value for instructors and/or students were recommended and displayed where possible.

The three days set aside for the workshop were arduous. Activities started at 8:00 A.M. with two coffee breaks of 15 minutes each at 9:45 A.M. and 3:15 P.M.; lunch 12:00-1:00 P.M.; rest period and dinner 4:00-6:00 P.M., and an evening session 6:00-8:00 P.M. Buzz sessions went on until midnight.

*Expert Committee on Psychiatric Nursing, *First Report*, Geneva: World Health Organization, Technical Report Series No. 105, 1956.

First Day

Following the welcome to the hospital and workshop by the director of nursing, the instructors settled down to work.

Basic human needs and mental health concepts were reviewed. Then the group formed into four sections for a visit to the wards under the guidance of the faculty of the Provincial Hospital. With deliberate intention nurses were not prepared for or oriented to this experience. A conference was held immediately following the ward visit to discuss feelings, attitudes and reactions. The need to prepare and orient students for clinical experience in psychiatric nursing was well demonstrated.

In the afternoon the groups returned to the wards with definite objectives in mind. They found this was a much more satisfying experience.

The evening session was centred around a comparison of patient care in general and mental hospitals and discussion of common misconceptions.

Second Day

The morning started with the delegates returning to the wards. A conference with their group leaders followed.

The film "Psychiatric Nursing" was shown and discussed for its value in interpreting psychiatric nursing to students.

After a brief introduction on behavioral disorders the instructors spent the remainder of the day applying principles and concepts of psychiatric nursing to nursing problems selected from Cardew's *Study Guide for Clinical Nursing*.**

Example: "The Sick Man from Skid Row"

Points to consider

i. Connotation of words: paddy-wagon as opposed to ambulance; unclean, unkept as opposed to dirty; scabies, lice, + 4 Kahn.

ii. Social class: Status and economics do not go hand in hand necessarily. The nurse, middle-class with middle-class standards and values, puts the emphasis on cleanliness, self-discipline and other "virtues." She has certain expectations

regarding the lower class. Its members should be grateful, less demanding, need less care, etc.

iii. Normal psychological responses to illness or the threat of incapacitation.

Selecting two concepts, "All behavior is meaningful" and "the dignity of man," a number of questions related to patient care were answered.

Third Day

Three major areas were stressed:

1. The preparation of students by the home school for psychiatric nursing affiliation.

2. The responsibility of the faculty and of the Provincial Hospital itself in regard to the affiliation program.

3. Follow-up of students after their affiliation experience.

The instructors from the general hospitals and the mental hospital discussed what they were prepared to do and what they felt each other's responsibility would be concerning affiliation.

The Responsibility of the Home School

1. Interpretation

Explanation of concepts of psychiatric nursing and mental illness to hospital boards, medical staffs and nursing personnel. Emphasis should be placed on attitudes. Attempts should be made to dispel the common idea that the "students have had a holiday and it is time to get back to work."

2. Preparation and orientation

a. Incorporation of mental health principles and concepts into the basic curriculum.

b. Use of discussion groups to provide an opportunity for students to disclose fears and anxieties without fear of retaliation or criticism. Sometimes misconceptions can be eliminated by another student who has had experience. Care should be taken in selecting the student for this purpose. She must be given guidance and supervision.

c. Audio-visual aids, such as films, which can be viewed and then thoroughly discussed, provide a helpful means of orientation.

d. Explanation of the differences between general and mental hospitals, e.g. the physical plant; the role of personnel, especially auxiliary staff; the patient's activity.

** Cardew, E. *Study Guide for Clinical Nursing*. Montreal: J. B. Lippincott, 2nd ed. 1961.

e. Preparation of a master plan of rotation. Affiliation is part of the master plan. Students should know in advance when they are to affiliate.

f. Selection of students for affiliation. It is regrettable that all students cannot be accepted at this time. It is hoped that the situation will be remedied. Selection of students should receive careful consideration. Some alternative should be offered to the remaining students.

g. Reading assignments and discussions one to two weeks before the date of affiliation will help to eliminate last-minute problems or anxieties and answer students' questions.

3. *Inter-hospital communication*

Both agencies should be fully aware of the other's objective philosophy and any major changes in it.

4. *Records*

Forms will be sent from the agency supplying affiliation to the home schools. These are to be completed and returned before the students leave for their affiliation.

Responsibilities of the Psychiatric Agency

1. *Facilities*

a. Residence: Students living-in are limited to those coming from outside the Greater Saint John Area. Single rooms are provided. Laundry, kitchen, library and classroom facilities are available.

b. Clinical Areas: These are designed according to the needs of students and the program.

2. *The Program*

a. It is based on the philosophy and objectives of the school of nursing of the agency.

b. Clinical instruction is provided.

c. The evaluation of the student is based on tests, examination assignments and performance during clinical experience.

c. Evaluation and revision of the program are carried out in accordance with objectives.

d. Copies of records and reports are sent to the home schools.

3. *The Affiliating Student*

a. Provision is made for orientation to the residence, hospital, and the city. Churches, shopping areas, recreational and transportation facilities are noted in relation to the latter.

b. Health needs are supervised by the faculty according to agreement.

c. Social life is provided for through a student committee with a member of the faculty as advisor.

Later Responsibilities of the Home School

1. Principles and concepts of psychiatric nursing must be applied to all nursing care in order to provide necessary continuity for the student.

2. It may be possible to plan special projects in connection with Mental Health Week.

Responsibility of all Schools

There should be regular meetings to discuss and evaluate the affiliation program. Psychiatric nursing is not a separate entity, it has basic principles and concepts common to all nursing.

Recommendations

Participants in the workshop recommended that:

1. The psychiatric nursing affiliation program should be interpreted to hospital personnel generally. It was felt that this was necessary to prevent such attitudes as "students have been on an eight-week holiday" and other misconceptions concerning psychiatric nursing and mental illness.

2. A course in psychiatric nursing should be offered to graduate nurses, especially those who are working with students and have not had previous experience in the care of the mentally ill.

Summary

Psychiatric nursing is a new experience for most nurses in New Brunswick. If the affiliation is to be valuable to the students the program must be well thought out, properly introduced and carefully followed up. This implies a grave responsibility for instructors, especially for those without any background in psychiatric nursing.

It is not possible to prepare all instructors, but many can be helped through this type of workshop. Even in three days much can be accomplished when the group is keen.

Fear, anxiety and misconception concerning the care of the mentally ill prevent the student from being objective. These inhibiting influences

must be eliminated, at least in part, if the student is to learn.

Orientation to the practice field is a joint responsibility of the faculties of the home school and the affiliate agency. The latter is responsible for the educational program, which includes helping the student to acquire psychiatric nursing principles and concepts; specific skills and techniques, and supervising her clinical experience.

The follow-up of students when they return from their affiliation is the responsibility of the home school. This will be meaningful only if the nurses on the wards know what is expected of them and are prepared to assist the student in the application of basic principles and concepts.

Records and reports are of importance in maintaining formal communication between the two schools. Joint conferences and informal methods should not be ignored or taken lightly.

An affiliation program is not designed to produce specialists in psychiatric nursing. Its purpose is to educate the student to be sensitive to the emotional difficulties of patients and

to help her understand her own feelings and attitudes.

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In the Good Old Days

(*The Canadian Nurse* — APRIL 1922)

The greatest handicap that schools of nursing have struggled under has been and still is lack of consideration by the very persons who should stand strongest behind them. Like all schools, their need is for a sound financial basis upon which to work. Do we expect schools for teachers to operate without funds from the state? If the school of nursing is to do its work efficiently, it is high time our Boards of Directors should look after its independent financing.

* * *

Such a widespread disease as tuberculosis requires intelligent nursing care. How can this be given if our nurses have no experience with its early manifestations, its treatment and control? No time should be lost in securing for every nurse in training both practical and theoretical knowledge of this disease.

* * *

(Advice to delegates to the national convention, held in Edmonton in June, 1922.)

Each delegate ought to feel that she is sure enough of the attitude of the association she

is representing to express herself in clear terms whenever a point is at issue. It is not advisable for delegates to be so bound down by fear of their associates at home that they cannot speak unless they have had instructions. Let us get away from the personal element and realize that we are not there as individuals but as representatives. The appointed delegate should be so conversant with the feelings of her group that she will know that what she says is the actual voice of her association.

* * *

"Nurses have lost sight of the real impulse of their profession. They are putting a prohibitive price on their ministrations to the sick. The educational standards for registration of nurses have gone beyond all reason."

— Dr. Charles Mayo, Rochester, Minn.

His suggested solution:

"Sub-nurses, nursing aids, etc. with less education and less training — girls who are contented with a fair wage and fair living conditions."

THE WORLD IS YOURS

RAE CHITTICK, M.A., LL.D.

We're the kind of people who believe a book is like love — a catalyst to new perspectives, new vistas, new understandings. We believe a book can warm a heart, open the eyes, shape a mind, and stimulate, motivate, activate new experiences and emotions. The world is yours when you wake up and read.

(Advertisement in *N.Y. Times* by Doubleday as quoted by Theresa Lynch on the *Improvement of Nursing Practice*, A.N.A. p. 33.)

WE ARE ALL average persons, but even the most average person is not average all the time. All of us have moments when we possess a desire for distinction, when we are sensitive to excellence; brief moments it may be of golden intuition when we can see to the flaming ramparts of the world and beyond. To renew and increase those moments, books are a sovereign prescription. And another thing, the reaching for that best which lies within the pages of a great book or a great poem deposits, as it were, a grain of iron in the mind which in later seasons gives us strength.

These words were spoken by Dr. Earl P. Scarlett of Calgary at the Canadian Nurses' Association Biennial Meeting in Sackville in 1948. He called his address *The Ram's Horn*, for it was a symbol of the wealth of reading to be found in his father's study. The ram's horn was the pictorial design on the cover of a theological magazine, but to Dr. Scarlett any memorable passage in his reading became a blast from this symbolic horn.

For many of us the horn blows only occasionally. There are too many diversions in modern living that take precious time and the "grain of iron" is not deposited to enrich our lives and deepen our understanding.

How should one read a book? This is the title of a well-known essay by Virginia Woolf. She begins by saying, "The only advice, indeed, that one person can give another is to take no advice, to follow your own instincts, to use your own reason, to come to your own conclusions." Independence is the most important quality a reader can possess and we should not let another tell us how to read, what to read, or what value to place upon what we

read. I agree wholeheartedly with Virginia Woolf and it is with this understanding that I offer a few ideas and suggestions.

Reading is a method of discovering what is passing in the minds of one's fellows, and since time is precious, one is better off to explore good minds than poor ones. For the inexperienced, who have difficulty in discriminating, there is a wealth of literature that time has proven great. Now that the works of so many recognized writers are being issued in paper-backs, it is possible for every one to have a personal collection. There is a great advantage in owning books, for it is by having books around you on all sides, available to almost any chair that you choose to sit in, that you learn the art of reading. There is a time for skimming, for sampling, for earnest application, for reflective browsing and for complete escape, and both the book and the



RAE CHITTICK

circumstances will determine what you do. What you skimmed one day may demand your whole attention at another time. A good many years ago John Ruskin said,

The very cheapness of literature is making even wise people forget that if a book is worth reading, it is worth buying. No book is worth anything which is not worth *much*; nor is it serviceable, until it has been read, and re-read, and loved and loved again; and marked, so that you can refer to the passages you want in it.³

Novels and plays take us into the hearts and minds of men and women to make us more aware of ideas, motives and values that influence the behavior of people. They help us to understand ourselves and our relationships with others. They stimulate the imagination, or the ability to speculate, and thus multiply our hypotheses about human nature and in so doing increase our capacity to solve problems.

If we search for awareness, if we search for entrancing and stimulating hypotheses, if we would strengthen our mind and our compassion by flights and trains of imagination based on life-contingent situations, here is the vehicle, at least as effective and intellectually commanding as the treatises, at least as authoritative.⁴

It is because general reading on a broad basis helps us to understand people and the world we live in, which is fundamental to nursing, that it is difficult for me to distinguish professional reading from *other* reading. One learns to understand life in a prairie village through the writings of W. O. Mitchell or Frederick Philip Grove as well as from the Cummings' sociological study of mental health in a Saskatchewan town. Gabrielle Roy's novels about Montreal are as revealing in their own way as Everett C. Hughes and other sociologists' analyses of changing French Canada. Each enriches the other and adds perspective and new meaning.

Yet we cannot work intelligently without professional reading. Our generation is the first to realize that "continuing education throughout life has become a necessity in almost every field of life, from housekeeping to

atomic physics."⁵ A great deal of what adults need to know today was unknown when they were young. It is through discriminating reading that an adult can build new knowledge on old and develop the kind of mature mind "which is able to make swift, accurate transference from older experience to new experience, because neither is felt as absolute or exclusive."⁶

One must approach professional literature with respect. Thoreau observed that no exercise implies more manhood and vigor than joining thought to thought and the average nurse is reluctant to attempt it for publication. I think we can assume that each piece published in a nursing journal represents the best the writer has to offer and as such deserves our consideration. One may be critical of the author's point of view or her method of expressing it, but that in itself has value, for our unacceptance makes us focus on the points presented, helps us marshal our own ideas and challenges us to further exploration. Of course, every article in a nursing journal is not meant to be read by every subscriber. One learns to select and this is where skimming or sampling has value. Even though one does not actually read the article, one becomes aware of the subject matter treated and unconsciously makes a mental note to be recalled later when one has need for this particular information.

Moreover, one never knows when a perfect gem will turn up that one will return to over and over. Here are a few highlights from recent journals that deserve reading and re-reading: Marie Jahoda, "Nursing as a Profession," *The Canadian Nurse*, September 1961; Robert J. Henle, "Liberal Education, a Basis for Nursing," *Nursing Outlook*, March 1961; Isabel Menzies, "Nurses Under Stress," *International Nursing Review*, December 1960; James Mackintosh, "Health, Medicine and Social Change," *Canadian Public Health Journal*, November 1961.

I have chosen these highlights from four professional magazines that I think should form the basis of professional reading for Canadian nurses. All of them should be available

through hospital libraries or the libraries of public health agencies. They are tools as basic to nursing as physical equipment.

You will be reading this sometime in the spring, but I am writing it on New Year's Eve. This, of course, is the night to extend good wishes and wishes take my mind back to fairy tales, those depositories of the wisdom of mankind that took cognizance of many things including wishes.

There is one particular fairy tale about wishes that I like very much. It has to do with an old and ugly woman who is shut up in a tree. She cries for help to all who pass by but no one can release her. Axes and pulleys, hammers and wedges have proven useless. At last one day a young poet passed by, happily singing to himself. "Let me out. Let me out," cried the old woman. The youth fetched an axe as a thousand men before him had done. The old woman was very old and very tired of young men and axes; they seemed to have only one idea, and always the axe flew out of their hands. She said patiently as she had said a thousand times before. "There is only one way: you must allow me to take your wish from you."

"But how did you know I had a wish?" asked the young man.

"Everyone has a wish," said the old woman.

The young man thought for a long time and then he began to sing a love song to the princess the old woman might have been if she had been young and beautiful and free. And when he was done, she was standing before him, free and very beautiful and young.

Without reading one is shut up in a prison. So, like the poet in my fairy story, I give you my wish, to love books, and, because it is given away, it is fulfilled; you are free and the world is yours.

References

1. Earl P. Scarlett, *The Ram's Horn*, *Canad. Nurs.*, Vol. 44, September 1948.
2. Virginia Woolf, *Great Essays*, ed. by Houston Peterson, New York: Pocket Books, Inc., 1954, p. 373.
3. John Ruskin, *Sesame and Lilies*, *Of King's Treasures*, Sect. 32.
4. Herman Finer, *Administration and Nursing Services*. Macmillan Co. of Canada, p. 299.
5. Margaret Mead, "Becoming an Education Man in our Modern World," *UNESCO Courier*, January 1961, p. 5.
6. *Ibid*, p. 7.
7. Charles Morgan, *Reflections in a Mirror*, Macmillan Co. of Canada, p. 79.

Canadian Library Week will be celebrated for the fourth consecutive year, April 8 to 14, 1962. The "Week" is actually the culmination of a continuous campaign for more and better library service.

Books are everybody's business. There was a time when a man could literally "know it all," but not now. Knowledge expands too fast. We cannot even know every facet of our own work without frequent reference to the printed page. Someone is always coming up with new techniques or new applications. We have become a "learning" society, for education cannot stop with the classroom.

Reading is the key to information, inspiration, entertainment. None of us can afford *all* the books we need or want. That is why we need libraries.

Education costs money, but in turn it creates wealth. Social and business life flourishes where there are libraries. The reverse is also true, not only in under-developed countries, but right here in Canada. Library

standards set \$2.00 per person as the desirable minimum for support. Some of our large cities spend up to \$5.35 per capita on public libraries. Yet the average figure for all of the country is a mere 68 cents. A lot of people are being short-changed, through apathy or ignorance.

Canadians who do not read are a drag on the nation's economy and culture. The non-reader finds it difficult to learn, and he is equally hard to teach. Unskilled workers are first to lose their jobs and go on relief, while positions that require training go unfilled.

In more ways than one, reading is a key to a richer life, one in which libraries play a major part.

* * *

A good book is the best of friends, the same today and forever. — MARTIN TUPPER

* * *

He was like the cock who thought the sun had risen to hear him crow

— GEORGE ELIOT

THE IMPACT OF CHANGE

CLAUDIA TENNANT

The following address was given during a panel discussion at the Associated Hospitals of Alberta annual convention in October, 1961. The impact of the changes in nursing on hospital costs is interpreted.

ONE OF THE greatest contributing factors in rising hospital costs today is the cost of nursing service and nursing education. The biggest criticism of nursing is not so much the increased cost as the fact that we have failed to keep the public informed of the change in the role of the nurse. From a public relations point of view we have sold ourselves short.

The modern world is full of scientific wonders. Society is a constantly changing scene. There is an ever-increasing struggle for mere existence. However, nowhere is this struggle for advancement, for change or for survival, more marked than in the field of health.

How has the change in the role of the professional nurse affected nursing service? Has nursing service increased to the same extent that the cost of nursing service has increased? We so often hear it said, "Where is the good old-fashioned nurse?" Nursing services appear to grow less and less and yet the cost of nursing service grows higher and higher.

The nurses of today aren't what they used to be! No, and neither is nursing. Hospitals have changed. Treatments and facilities have changed. The only common denominator is the patient, and even the patient has changed beyond all recognition.

I hope I can interpret to you just a few of the problems, the headaches, the frustrations inherent in trying to give nursing service today.

It has so often been said that comparisons are odious. However, for the lack of a better method of interpretation, compare nursing today to nursing as we learned the art as students some 20 years ago.

The aging population with the problems inherent in nursing them; improved methods of anesthesia; improved surgical techniques; increased numbers of medications, particularly

the antibiotics, as well as the advances in intravenous therapy and the use of blood transfusions all contribute towards this change. Early ambulation is the form of treatment that causes the biggest rift today between the patient and the nurse. The doctor orders the patient to be up. The patient doesn't feel like getting up. It is next to impossible to convince even the best natured patient that early ambulation isn't just a means of the nurse getting out of work. Tender, loving care has been replaced by pills and needles. The nurse who spends her time giving injections and medications and making a patient help himself is just as much interested in the welfare of the patient as the nurse who spends her time soothing the fevered brow and fluffing up pillows.

Other forms of modern equipment that add so much to the comfort and welfare of the patient take time, effort and much skill to run. For the most part you cannot teach anyone to use this complicated equipment with the patient in it unless you work right with that person full time. Trial and error and effort are not enough to assure the maximum use of equipment.

Oxygen tents: When needed they are wanted in a hurry and they must work effectively. The efficient running is complicated and important.

Croupettes: In my student days the biggest scourge of winter was croup. We seldom see a death from croup now. If a child is gasping for breath, the handling of this equipment cannot be left in the hands of amateurs. But try and convince a mother with a croupy child that the nurse who takes her child and places him in a croupette and treats him with oxygen and antibiotics, is as kind and loving as the one who fondles and caresses the child and holds him in her arms. Yet the nurse of today helps to save more lives with fewer complications, and is just as dedicated as

the nurse who cared for the croupy child before the days of adequate oxygen supply, antibiotics and croupettes.

Isolettes: The premature baby is rarely handled but he needs constant attention and supervision. Just a short time ago the mother of a premature baby, raised from a mere two pounds and six ounces, was heard to say "My baby was raised in the Isolette — never out of the Isolette — never touched by human hands." Little did she appreciate the hours of tender loving care around the clock so that her baby might live.

We are to blame. We in nursing are selling ourselves short. Our interpretation of nursing service to the public is poorly done. For example, oxygen is used so much more today than 10 or 20 years ago. Patients with oxygen require *more* observation, *more* attention and *more* nursing. The new, electric gastric suction is infinitely more comfortable and more efficient than the Wangensteens of yesterday. They also require more time to learn to run them and to keep them in working order. One patient with a Wangenstein on an average ward in my day was a worry. Now our 48-bed surgical ward has a stock of six, and it is not a rare thing to have all six in use at once.

Taking blood pressures 20 years ago was a medical procedure. Now it has become a routine for every admission and has progressed from a doctor's responsibility to the nurse's, or even the nursing aide's duty. Patients with toxemia, head injuries, shock or coronary thrombosis have blood pressures ordered from every five minutes to every hour, depending on their condition. These nursing hours again contribute to cost.

Let us compare the care of two similar patients, one of 20 years ago, and the other today, admitted to the hospital with pneumonia. Yesterday he had practically nothing but T.L.C. for four to six weeks. He was nursed in bed; given oxygen only for cyanosis; treated with mustard plasters, given bed baths and back rubs. The only medicines were aspirin and a laxative. The patient knew his nurse; the nurse knew her patient. Each looked forward to their daily company.

Today, the average stay in hospital

is seven to ten days. Bathroom privileges are permitted on admission. Oxygen is used if it adds to the patient's comfort. Injections and pills are administered in varying quantities, styles and colors. Try to find the patient after the first 24 hours to give him his treatments. The patient doesn't know one nurse from the other. The nurse needs an identification band to find the right patient. This patient never feels that he's had any nursing.

A similar comparison could be made between two surgical patients and the picture is even more dramatic.

Medicines do not take the place of T.L.C. but the nurse seems so busy with medications, that she hasn't time to do everything, so it's the T.L.C. that falls short.

In my student days a nurse was assigned six patients. She did everything for those patients seven days a week, and furthermore, she had time to do it. If the patient wasn't bathed by 10:00 A.M., he wasn't going any place anyway. He appreciated the after-breakfast nap. As long as our patients were cared for and the room completed by noon so that one-half of the staff could go on split hours, all was well. If you weren't finished, you stayed until you were, and had two hours off instead of three. It didn't make much difference, you weren't going anywhere either. One-half day a week was really appreciated.

Now, the patient expects to be done by 9:00 A.M. He wants to be up and visiting. He's lonesome in a room by himself, and being up is part of his treatment. In addition, there are physiotherapy, X-ray and any number of other places to go for treatment.

The nurse feels the pressure of extras in medications, requisitions, injections, records, treatments. The most a nurse can be expected to do now, with all the extras, is four patients. This nurse is no less efficient than we were.

Is it generally appreciated that early ambulation is so time-consuming? I could make a bed with the patient in it in less time than I can get the patient up, make his bed and then find him when his medications and treatments are due. It used to be wonderful to know exactly where your patients were — and those patients felt nursed.

In preparing this material, I did a study on our surgical floor for a one-day period. There were:

288 pills given and charted, an average of six per patient.

135 injections: prepare medication, locate the patient, return him to his room for administration, chart the medication and clean up the equipment.

10 I.V.'s started, stopped, watched and charted.

4 blood transfusions: a nurse brought the blood from the lab and had it checked and signed for; assisted the doctor; watched the patient during the administration.

22 dressings.

42 requisitions for the laboratory, pharmacy, X-ray, physiotherapy, etc.

7 delayed meals because of fasting X-rays, lab. tests and late admissions.

In addition there was the usual routine of admitting and discharging, and the usual number of new surgical patients to care for.

There are many factors to consider when talking of the changing role in nursing. Yesterday, we nursed our patients in large wards for the most part. The nurse was constantly under the observation of her patient. As long as she was in the room her patient appreciated the fact that she was on hand, but that she was busy. We never heard it said then that the patients never saw the nurse, as we so often hear it today. The patients had each other for company. They did not get lonesome.

Today, the trend is toward smaller rooms and to nursing the seriously ill patient in the private room. The average patient does not know what the nurse is doing to keep her out of his sight. He is restless and insecure because the nurse is not on hand. To even say "Good Morning," to 10 patients probably means entering five rooms. One "good morning" used to satisfy 10 patients.

It is regrettable, and the nurse feels it most of all, that she cannot afford the time to give the patient strength by her mere presence at the bedside as she used to. There are so many other things called "nursing" to be done.

It all seems to be a question of time. Today, we seem to be expected to do everything we used to do 20 years ago, plus so many extras. The increase in laboratory and X-ray work adds so

much to the nursing load. Delayed breakfasts, fasting bloods, catheter specimens, enemas till clear, besides the interpretation of so much of this to the patient, all adds to nursing hours which represent dollars. The doctors complain that the nurse spends too much time at the desk. Who is going to write the requisitions?

Because of all the extra tasks that have become part of nursing, other groups of employees have also become part of the nursing team.

Nursing aides have assumed an important role. They do a considerable part of the direct patient care, while the nurse has receded from the bedside. In this regard the nurse has sacrificed much. The average nurse *wants* to nurse, but with so much outside pressure and so many other activities that are now called nursing, she can't get "within a mile" of her patient.

With the increase in male urology and in orthopedics, the role of the orderly has become very important. Who trains the orderly?

In fact, who is responsible for in-service programs of all types — ward clerks, ward aides, etc.? Should time spent by the nurse doing this be charged to nursing?

As we delve further into this situation, we ask again: How does the role of the nurse in 1941, differ from the role of the nurse in 1961? Yesterday we found the nurse at the bedside ministering to the sick and the suffering. Yesterday we thought of our task as caring for the sick. The prevention of illness was something to be taken care of by the community.

Today, in hospitals, we find the nurse engaged in planning, managing, ordering, teaching, giving medications by the gross, operating intricate machinery, keeping complicated records, in fact doing anything and everything but bedside care.

Nursing service costs have risen, and are continuing to rise. I was happy, as a young graduate, to get \$50 a month. Now new graduates start at \$285. Nurses are not by any means the highest paid workers. As young graduates, we worked 48 hours a week. One full day off was wonderful. Graduates now have two days off; a forty-hour week, and why not? Everyone else does. We worked two shifts and

covered the 12-hour period with broken hours. Now we have three shifts to cover the 24 hours. But why shouldn't nurses work hours comparable to other groups?

In my student days, 300 hours of instruction in the classroom seemed adequate for the student nurse. We had an apprenticeship method of nursing education. The "probie" was assigned to another student nurse, and worked along with her to learn the art of nursing.

Today this is not possible. The average nurse is expected to race along and the poor probationer can not keep up to her. The student of today requires from 1000 to 1200 hours of classroom instruction, and then adequate supervision to carry out the instruction. The student nurse cannot be counted on for service as she could be 20 years ago. Supervision is costly, and someone must pay for student education as well as for nursing service.

Nursing should be divided into two categories — direct and indirect care. Most of the old-fashioned nursing was direct care. Most of the modern additions are indirect care. I would estimate that 20 years ago the nurse gave 90 per cent direct care and 10 per cent indirect care. Today, I would say, the nurse barely gives 10 per cent direct care. It is the direct care that the patient calls nursing. However, the indirect care represents hours and dollars.

I have gone back 20 years, instead of forecasting the years ahead. I feel that the changes of the past years have been so poorly understood, so poorly interpreted that, without an understanding of the past, it would be impossible to forecast the future.

The trend today is toward more and more indirect care, and less and less direct care. Could the administrative load of the nurse be lightened? Ward clerks have helped considerably. Could

not better use be made of automation in order that indirect patient care could be converted to direct patient care? It is inevitable that some changes must take place.

The patient wants the nurse to give him strength by her mere presence at his side. This takes time and nurses and dollars.

The doctor wants the nurse to be with the patient, to do nursing care herself, and not to see that it is carried out by some system of remote control. This takes time and nurses and dollars.

The nurse wants to be with her patient. She wants time to be that good old-fashioned nurse. She wants a faster, better way to do the indirect patient care. She wants time to be a nurse. This takes time and nurses and dollars.

The main concern of all in the health field is how to provide nursing for the patients in the increasing number of hospital beds. Nursing accepts the challenge.

It is concerned about rising costs.

It is concerned about obtaining a sufficient number of nurses to meet the demands.

It is concerned about making better use of nursing hours in order that the nurse can be at the bedside.

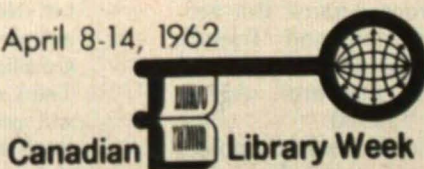
It is concerned about the increase in indirect patient care and the decrease in direct patient care.

In fact, it is concerned about nursing.

Hospital costs from a nursing service point of view will continue to rise as long as there is a need for more and better trained nurses. If the public wants professional nursing service it must be prepared to meet the cost of nursing education and nursing service. Remember, however, in all of this, that the "pearl of great price" is mutual understanding.

Reading is the key

April 8-14, 1962



THE WORLD OF NURSING



PREPARED IN YOUR NATIONAL OFFICE, CANADIAN NURSES' ASSOCIATION,
74 STANLEY AVENUE, OTTAWA

The Agnes Campbell Neill Memorial Award

Through an educational award, the members of the Nursing Sisters' Association of Canada are proud to honor the memory of Matron-in-Chief AGNES CAMPBELL NEILL, O.B.E., R.R.C., LL.D.

A graduate of the Toronto General Hospital, Agnes Neill served for 10 years in increasingly important supervisory and teaching positions in her own hospital and school of nursing. The latter part of this time was spent as junior assistant to the renowned JEAN I. GUNN, superintendent of nurses. As an international student at Bedford College, London, England, 1935-36, Miss Neill gained knowledge of hospital administration which was reflected later in her able organization of the overseas nursing service of the Royal Canadian Army Medical Corps. She enlisted during the first month of World War II and was assigned overseas duty as a Captain (Matron), RCAMC. Her record of service to her country and to her calling "tells better than any words the story of Agnes Neill, the woman, the nurse, the officer." To these words, every nursing sister whose privilege it was to serve with her, would unquestionably wish to add "the friend."

Returning to civilian life, her great heart for justice to veterans naturally drew her to a position with the Department of Veterans Affairs. But veterans, doctors, nurses and friends everywhere were all too soon to be saddened beyond measure. Agnes Neill died on May 5, 1950.

As a loving remembrance of a noble, happy person; as a symbol of her outstanding professional leadership; as

a continuation of her life's work, the second Agnes C. Neill Memorial Award will be presented during the 31st Biennial Meeting of the Canadian Nurses' Association in Vancouver, June 25-29, 1962.

The following information regarding this Award is inserted for the benefit of those nurses who might wish to apply.

Award

1. The amount of the Award shall be \$500.
2. The Award shall be given every two years to a suitable candidate who is planning to further her nursing education through university study and who meets the requirements set up by the Nursing Sisters' Association.

Applicants

1. Applicants for the Award shall be nurses who are registered in a province in Canada. Preference shall be given to:
 - a. Former nursing sisters who have served in Her Majesty's forces;
 - b. Relatives of nursing sisters or veterans;
 - c. Other veterans who have served in the Allied forces.

Applications

1. Application forms may be obtained from the Canadian Nurses' Association, 74 Stanley Avenue, Ottawa.
2. The processing of applications will be carried out by the Agnes Campbell Neill Memorial Award Committee with the assistance of the Canadian Nurses' Association.
3. The Canadian Nurses' Association will provide professional advice to the Nursing Sisters' Association or their representatives with regard to qualifications of applicants.

4. All applications must be received at the Canadian Nurses' Association headquarters not later than May 1, 1962.

Emergency Health Services

The second meeting of the Emergency Health Services Advisory Committee was held in Ottawa in November, 1961.

Members of the committee representing medical and paramedical associations and the armed forces discussed such topics as sources and control of health manpower in time of emergency planning; the Emergency Health Services Division program; public information for the maintenance of health standards under disaster conditions.

Dr. G. D. W. CAMERON, Deputy Minister of Health, Department of National Health and Welfare acted as chairman with Dr. A. C. HARDMAN of the department's Emergency Health Services, as secretary. M. PEARL STIVER, Executive Director, CNA, is a member of this committee.

AHA Institute

An institute on obstetrical nursing service administration conducted by the American Hospital Association in cooperation with the Department of Hospital Nursing of the National League for Nursing will be held at the Statler-Hilton Hotel, Buffalo, N.Y., April 30-May 3, 1962.

This institute is designed to explore some of the newer techniques and current managerial trends related to departmental management. The topics to be presented will relate to the application of recommended management principles and supervisory techniques.

Obstetrical supervisors who are actively engaged in the over-all administration of obstetrical nursing depart-

ments may register to attend by contacting the American Hospital Association, 840 North Lake Shore Drive, Chicago 11, Illinois.

World Health Day

The subject selected for World Health Day, April 7, 1962, is the prevention of blindness. Here is a quotation from a letter by the Director General of WHO:

In almost every country of the world large numbers of people have partially or entirely lost their sight, through accidents that need not have happened, or as a result of preventable diseases such as trachoma, smallpox, etc.

The aim of World Health Day, 1962 is to bring this problem to the attention of all sections of the public and to stimulate action to reduce the amount of unnecessary blindness in the world.

Canadian Red Cross

Members of the Canadian Red Cross medical teams who served in the Congo have been honored by the League of Red Cross Societies and the International Committee of the Red Cross. The twelve doctors and six nurses each received a commemorative medal from the International Committee of the Red Cross and a citation from the League of Red Cross Societies.

Did You Know?

Twenty-seven students from the Sudan and the United Arab Republic received their bachelor of nursing degrees in 1961 from the Higher Institute of Nursing in Alexandria, Egypt. This was the third and largest graduating class at the Institute which was established in 1955 to raise the standards of nursing in the Eastern Mediterranean region.

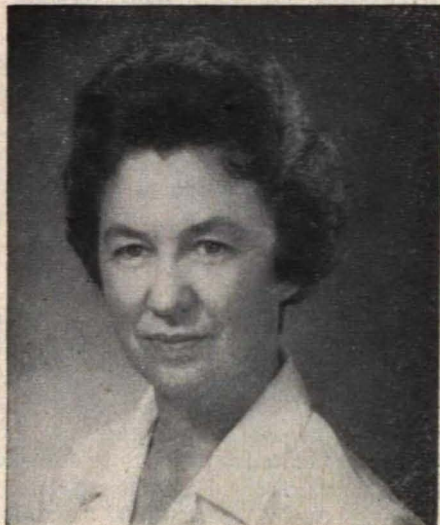
An important conference, sponsored by the International Union for Health Education and in collaboration with the World Health Organization, is to be held in Philadelphia, Pa. from June 30 to July 7, 1962. Every day there will be plenary technical sessions and panel discussions; some of the important subjects to be included are: Research in Health Education; Professional

Training in Health Education; Man's Responsibilities for the Control of his Health Environment; Potentialities of Education for meeting Major Health Needs.

Those who are interested in obtaining further information concerning the conference, may write to the Executive Secretary, IUHE, Miss Susan King-Hall, 3 rue Viollier, Geneva, Switzerland.

NURSING PROFILES

Verna Huffman is returning to the Department of National Health and Welfare, Ottawa after over two years of international service with the World Health Organization. During her leave of absence she was stationed in the Caribbean area as nursing consultant to the ministries of health of British Guiana, Barbados and Trinidad.



VERNA HUFFMAN

A graduate of the Civic Hospital, Peterborough, Ont., Miss Huffman secured her diploma in public health nursing from the University of Toronto. Later, she studied at Columbia University where she completed requirements for a Bachelor of Science degree. Prior to joining the Department of National Health and Welfare in 1947, she was on the staff of the Victorian Order of Nurses in Toronto, Guelph and Montreal. Miss Huffman also worked with underprivileged children under the auspices of the Kiwanis Club of Toronto.

From 1947 until her assignment with WHO, she was a senior nursing counsellor on the staff of the Civil Service Health Division. Now she takes up the duties of a public health nursing consultant, working in close association with DOROTHY M. PERCY, chief nursing consultant, Department of National Health and Welfare.

Margaret Mary Street has joined the staff of the School of Nursing, University of British Columbia, as assistant professor. She

is teaching nursing service administration to students enrolled in the new diploma course in administration of hospital nursing units offered by the University. Miss Street also conducts a course in supervision for students in the final year of the basic degree program.

Obtaining a bachelor of arts degree from the University of Manitoba and training as a teacher at the Provincial Normal School, Winnipeg preceded her entrance into the nursing profession. Since graduation, Miss Street has had a busy and varied career. She was on the teaching staff of St. Joseph's Hospital, Victoria for a short time before going to the Vancouver General where she eventually became assistant night supervisor. In 1941, Miss Street returned to Montreal for further study and obtained her certificate in teaching and supervision from the McGill School for Graduate Nurses. At that time she was awarded the Board of Governors' Scholarship of R.V.H., Montreal. Quite recently she completed requirements for her Master of Science from Boston University, majoring in nursing service administration.



(Dept. of Extension, U.B.C.)

MARGARET STREET

She is a former executive secretary of the Manitoba Association of Registered Nurses and a former secretary-registrar and visitor to English schools of nursing of the Association of Nurses of the Province of Quebec. In addition she has served on the staffs of her home hospital and Misericordia Hospital,

Winnipeg as a clinical instructor. Most recently, 1953-60, Miss Street was associate director of nursing, Calgary General Hospital.

She is a past president of the Alberta Association of Registered Nurses and has taken an active part in various other professional activities. During the CNA Pilot Project, Miss Street served as a regional visitor to schools of nursing.



LAURENCE CREVIER-HAMEL

The appointment has been announced of **Laurence Crevier-Hamel** as coordinator for the French division of the Extension Course in Nursing Unit Administration offered jointly by the Canadian Nurses' Association and the Canadian Hospital Association.

A native of Quebec province, born in Ville Saint-Laurent, she is a graduate of Hotel Dieu Hospital, Montreal and holds her certificate in administration and teaching from Institut Marguerite d'Youville, Montreal. Her past experience has included private nursing in her home hospital; clinical instruction at Hôpital Saint-Luc, Montreal where she also taught medicine and pharmacology and was responsible for coordination of clinical teaching programs. Mme Crevier-Hamel was one of the examiners in medicine for French nursing students 1950-55 and part-time registrar at Régistre Ville-Marie, Montreal, during 1951.

Off-duty she is a hockey fan and an active sportswoman with an interest in skiing, bowling, badminton and tennis.

The Extension Course in Nursing Unit Administration has been enthusiastically supported by English-speaking nurses. The

Canadian Nurses' Association and the Canadian Hospital Association are pleased to be able to offer the same opportunity for study to nurses of the French language.

The Nursing Branch of the Ontario Department of Health has announced the appointment of **Patricia Susan Bouchier Anderson** as inspector of schools of nursing for the province.

Miss Anderson was born in Ontario and obtained her early education there. She is a graduate of Toronto's Hospital for Sick Children and of the University of British Columbia where she obtained her Bachelor of Science in Nursing degree. She was awarded the Helen L. Balfour prize for obtaining highest standing throughout her four years course of study at U.B.C. She was formerly on the teaching staff of H.S.C., first as a clinical instructor and most recently as supervisor of the in-service educational program.



PATRICIA ANDERSON

Early this year the Tuberculosis Hospital, Saint John, N.B. appointed a new director of nursing — **Mary Isabel Lane**.

A graduate of Montreal General Hospital, Miss Lane is a Maritimer by birth and obtained much of her education in the province of New Brunswick. She took teacher training at the Provincial Normal School, Fredericton and later obtained her bachelor of arts degree from the University of New Brunswick. Following her graduation from M.G.H., Miss Lane had post-basic experience in communicable disease nursing at the Alexandra Hospital, Montreal and in tuberculosis nursing at the Saint John Tuberculosis Hospital,



ISABEL LANE

N.B. In 1943 she returned to Montreal for study at the School for Graduate Nurses, McGill University, and received her diploma in teaching and supervision.

Miss Lane has had several years' experience in public health nursing with the New Brunswick Department of Health. She was an instructor on the staff of Fredericton's Victoria Public Hospital 1941-48 and provincial school of nursing advisor 1951-58. She comes to her new position with considerable knowledge in the field of tuberculosis nursing since her past experience also includes three years as a staff nurse at Saint John Tuberculosis Hospital. She has taken an active part in professional activities in various capacities including convenership of the Committee on Legislation, NBARN and membership on the Council and the Credentials Committee, NBARN.

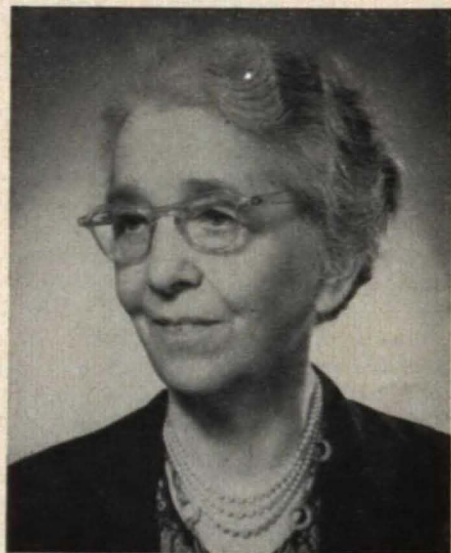


HELEN McARTHUR

One of the best known of our Canadian nurses, **Helen G. McArthur**, has been honored by the executive committee of the League of Red Cross Societies which met in Prague, Czechoslovakia recently. Miss McArthur, the national director of nursing services for the Canadian Red Cross Society, has been appointed chairman of the League's nursing advisory committee. Miss JANE MARTIN, director of nursing and social welfare service of the French Red Cross, is vice-chairman.

The committee which is appointed for a four-year term is composed of representatives of Red Cross, Red Crescent, Red Lion and Sun Societies from Canada, Denmark, France, the German Federal Republic, Greece, India, Iran, Italy, Norway, Poland, Rumania, Turkey, the United Kingdom, United States and Venezuela.

One of the first projects to be undertaken under the direction of Miss McArthur and her committee will be the selection of Red Cross personnel on a standby basis for service as chief nurses during any international disasters.



ISOBEL M. STEWART

A former Canadian who built a distinguished career for herself in the United States — **Isobel Maitland Stewart** — recently celebrated her 84th birthday. Miss Stewart is Professor Emeritus of Nursing Education, Teachers College, Columbia University. Many will recall the thrill of hearing her speak at the 1960 Biennial Convention when she was made an honorary member of the Canadian Nurses' Association.

The Registered Nurses' Association of Ontario has announced the appointment of **Dorothy R. Colquhoun** to fill a newly established position, Director of Testing. Her responsibility will be to develop an objective, machine-scored type of examination for Ontario nurse registration purposes. In preparation for this, Miss Colquhoun has already obtained a Master's degree in Educational and Psychological Measurement. She is working towards her doctorate in the same field.



DOROTHY COLQUHOUN

Marjorie G. Russell has been appointed to the staff of the RNAO on a temporary basis to assist **DORIS GIBNEY**, assistant executive secretary, and to free **LAURA BARR**, executive secretary, for further university study. Miss Russell, a graduate of the Hospital for Sick Children, Toronto, is well-known to former nursing sisters and nurses

who have worked with the Department of Veterans Affairs. Her most recent appointment was as nursing consultant to that department.

While she is on staff, Miss Russell was responsible for one particularly important project. She carried out research and secretarial duties for the special group charged with the preparation of an RNAO brief for submission to the Royal Commission on Health Services in Canada.

Marion Myers has retired from active nursing to her home in Grand Manan, N.B. For the past 13 years she has been the director of nursing, Saint John Tuberculosis Hospital, East Saint John, N.B.

A Nova Scotian by birth, Miss Myers came to Montreal General Hospital for her nurse's training and did postgraduate study at the McGill School for Graduate Nurses. She travelled westward for a three-year period as an instructor in a hospital in Moose Jaw, Saskatchewan, then returned to the Maritimes and Saint John General Hospital where she taught for 16 years, 1932-48.

She will be missed by the provincial nursing association for she was an active, enthusiastic committee worker at both provincial and local levels. She is a past president of the NBARN and also served as a first vice-president of the CNA. Miss Myers was on the executive of the Women's Canadian Club, Saint John branch for many years and was its president for a two-year term of office. The good wishes of her friends and colleagues go with her for a happy future.

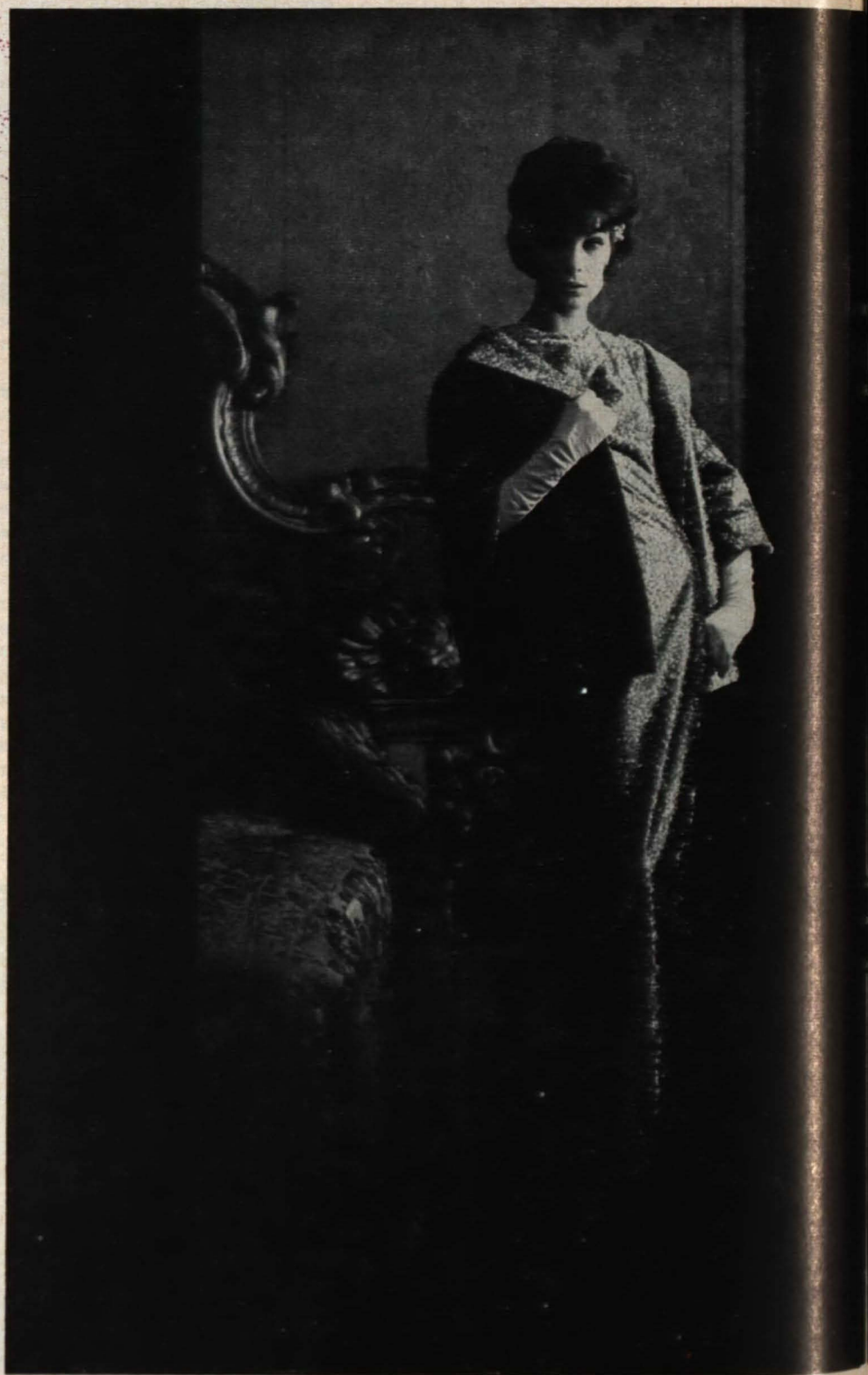
Congratulations to **Margaret (Hannah) Niven** who celebrated her 100th birthday on March 16, 1962. Mrs. Niven, who is a patient at Parkwood Hospital, London, Ont. graduated from the Royal Victoria Hospital, Montreal in 1898.

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references: 1. Prueter, G. W.: Applied Therapeutics 3:351, 1961. 2. Taylor, F. A.: West J. Surg., Obstet. & Gynec. 64:280, 1956. 3. Ainslie, W. H.: Obstet. & Gynec. 13:185, 1959. 4. Pearse, H. A., and Trisler, J. D.: Clin. Med. 4:1081, 1957.

*menorrhagia

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Samples and literature from



Health Problems in Various Age Groups

DOROTHY ROWLES, B.N.

A study of the physical, mental and social conditions associated with specific age groups.

EVERETT HUGHES, a noted sociologist, has said that nurses are the most self-conscious of all the professional groups. If this is so, we should be very pleased for it is an accepted belief among nurses that to understand mankind, one must begin by looking within oneself. This involves study of feelings, beliefs, knowledge, reactions to others and others' reactions to oneself.

Nursing literature is full of this kind of introspection as the following well known titles indicate:

Twenty Thousand Nurses Tell Their Story

Talking with Patients

On Becoming a Nurse

The Give and Take in Hospitals

Change and Dilemma in the Nursing Profession

Improving Nurse-Patient Communications

What Acceptance Means to Patients.

The great emphasis on this kind of material indicates that we are far from satisfied with individual performance. Improving individual nursing care is vital to the improvement of nursing service. It is conceivable, however, that in concentrating on ourselves, on our relationships to others and on patients' individual needs, we, as members of a profession, may be losing sight of the profession's obligation to society as a whole.

Society gives a profession considerable autonomy in performing certain functions. It does this because experience has shown that to get important jobs done efficiently, they must be done by experts. These experts are also expected to be the best judges of the amount of expertness needed. To ensure the continued right to autonomy in the performance of its functions within society, a profession must, in return, provide society with sufficient experts to perform those functions.

Nursing as a profession has ac-

cepted the obligation to supply society with adequate nursing care. The provision of such care is dependent on well-organized nursing services and good educational programs.

This paper is mainly concerned with studying Ontario's nursing needs. With a population of over six million people this becomes a difficult problem, especially, when we know that 45 per cent of that population is either under 20 or over 65 years of age. This leaves 55 per cent in the working age group. By 1976 it is estimated that the proportion will be 50-50. This means that, in the near future, half of the population will be supporting the educational, economic and health programs for all.

In 1958, there were approximately 26,000 registered nurses in Ontario or 1 nurse to every 210 persons — the second highest ratio in Canada. The great majority of full-time graduate nurses are working in general hospitals — 10,818 in 1959. In public health work official health agencies employed 1,038 nurses, industry 681, and the V.O.N. 360. Mental hospitals employed 811 graduate nurses, sanatoria 335. It is estimated that some 2000 nurses are engaged in private nursing.

As individuals, these nurses will see that their patients receive adequate care. However, single individuals scattered throughout various areas of nursing cannot direct the course of the profession. This can only be done collectively. It is the function of the professional organization to study and plan the type of organization and education necessary in nursing.

What are Ontario's nursing needs?

Nursing is concerned with assisting individuals to attain and maintain a state of complete physical, mental and social well-being. To identify nursing needs one must investigate conditions which interfere with the well-being or health of individuals.

The physical, mental and emotional components of health are so interwoven that to separate one from the other is to imply separate entities that have little relation to each other. However, in order to compile statistical material one must set up categories. To find out what health problems exist in Ontario, I have arbitrarily chosen to study the physical, mental, and social conditions associated with specific age groups:

1. Pre-school and school age children up to the age of 15 years, excluding those under one year of age;
2. adolescents and young adults, 15-24 years of age;
3. the young married group, 25-44 years of age;
4. the middle age group, 45-64 years of age;
5. the older age group, 65 and over.

Before describing these health problems, I would like to explain the use of two sources of material. For the morbidity picture, I have used the Canadian Sickness Survey conducted by the Department of National Health and Welfare in 1950. This material is 12 years old but is still the best source available. The 10,000 families included in the study kept a daily record of all illnesses, health care and cost of health care for a year.

An illness was a deviation from a state of good health as recognized by the person actually suffering the illness or by the household spokesman. Unless the person suffering the illness sought medical care, the classification of the symptoms was not verified by any clinical standard. For example, if a person said he had "flu," the illness was recorded as influenza, whether a doctor diagnosed the illness or not.

The duration of an illness was recorded in terms of complaint, disability, and bed periods. A complaint period was the length of time during which a person was at no time free of symptoms; a disability period was the number of consecutive days a person was away from his usual activities due to illness; and bed days were days in bed at home or in hospital. For instance, with a common cold a person might have 10 complaint days, out of these 10 days he was home from work 3 days and spent one day in bed.

If our aim is a state of complete

well-being for all, then the diseases causing the greatest number of complaint days are as important as those diseases causing less misery but more dramatic results. For this reason, I have included in the description of health problems those diseases causing the greatest number of complaint days as well as the diseases causing death or admission to hospital. Incidentally, 4 out of 5 persons in the study reported some degree of illness over the year period. In any one day of the study year 1 in 8 males and 1 in every 6 females was ill. If that proportion of ill to well persons holds true today 4,870,000 persons in Ontario were ill at some time during 1960.

The Canadian Sickness Survey, then, was one source. The second source was the Report of the Ontario Health Survey Committee from which figures for hospital admissions were obtained. This committee was formed in 1948 and the report issued in 1950. Therefore, the material obtained from this report is also 12 years old.

Pre-School and School Age Children

This is an age group whose greatest social difficulties arise from within the family. Community Mental Health Services in Ontario reports that the vast majority of children under their care are suffering from "primary childhood behavior disorders." In urban areas one of the major social problems appears to be lack of play and recreational facilities.

Children in this age group die mainly from: accidental causes including poisoning and violence; pneumonia and bronchitis; cancer; and congenital malformations in that order. Accidents account for 42% of total deaths.

The most common illnesses for the pre-school and school age child are the common cold and influenza. These two produce 50% of all illnesses. Measles, and disorders of the stomach and duodenum are the next most common diseases for children. The greatest number of complaint days result from diseases of the respiratory system; infective and parasitic diseases; symptoms and ill-defined conditions (mainly respiratory and gastro-intestinal symptoms); and diseases of the skin and cellular tissue.

In mental institutions, the majority of pre-school and school age children are admitted because of mental deficiency (85%) and epilepsy with mental deficiency (13.1%).

The main health problems for this age group then appear to be:

- Social problems stemming from unhealthy family relationships
- mental deficiency and epilepsy
- accidents
- cancer
- diseases of the respiratory and digestive systems
- infective and parasitic diseases.

Adolescents

Adolescents have fewer illnesses and fewer days of illness than any other age group.

The main causes of death for 15 to 24 year olds are: accidental causes (58%); cancer; suicide and self-inflicted injuries; and pneumonia, bronchitis and influenza. However, this group has the lowest death rate of any age group.

The most common illnesses suffered by young people are again the common cold and influenza (47.9%) with headache and acute pharyngitis accounting for another 7%.

The greatest number of complaint days are due to diseases of the respiratory system; symptoms and ill-defined conditions such as headache; diseases of the skin and cellular tissue; and accidents, poisoning and violence.

The greatest number of cases and days of hospital care were due to: normal deliveries and complications of pregnancy and the puerperium; diseases of the digestive and respiratory systems; and accidents, poisoning and violence.

The greatest number of persons in this age group in mental institutions are there because of mental deficiency. Schizophrenic disorders account for the next largest group with epilepsy running a close third.

The adolescent faces two major social problems. The first is the continually narrowing field of employment for the semi-skilled and unskilled worker; second, the gap between biological and social possibilities in sexual behavior. If these young people stay in school, they remain economic infants although they are biologically

mature. That this dichotomy between social and biological maturity is a problem for this age group is demonstrated by the fact that, in 1958, three homes for unmarried mothers indicated that over half of its clients were teenagers.

In summary, adolescents have fewer illnesses and fewer days of illness than any other age group. Their chief health problems are:

- accidents, poisoning and violence
- delivery and complications of pregnancy
- cancer
- pneumonia, bronchitis and influenza
- the common cold
- mental deficiency and epilepsy
- schizophrenic disorders
- unemployment linked with insufficient educational maturity.

Comparing the problems of adolescents with the problems of children, certain similarities and differences become obvious. Accidents, poisoning and violence, cancer, and respiratory diseases such as pneumonia and bronchitis are common to both. The common cold and influenza interfere with the daily lives of children and adolescents, although children have more infectious diseases, such as measles.

Mental deficiency and epilepsy affect a large proportion of both groups, but schizophrenic disorders do not become a major problem until childhood has passed.

The child is affected primarily by family relationships, the adolescent by economic, educational and sexual problems.

The Young Adult

For the majority of persons between 25 and 44 years of age this is the period of life when they are concerned with establishing a home, becoming economically self-sufficient and providing themselves in a chosen career. Professor Horwitz of the School of Social Work has stated that the main social problems for the young married group are:

1. Marital discord arising from differences in beliefs as to correct child rearing practices and from financial difficulties due in many cases to inadequate budgeting skill;
2. lack of effective communication between family members.

For the single individual within this age group, Professor Horwitz stated that loneliness, because of the effort which must be made to find opportunities for socialization, is probably the greatest health hazard.

For both the single and married person alcoholism was a major social problem.

Some support for these opinions may be obtained from the following facts.

1. It is parents in this age group who are providing the home environments for the group of psychologically and socially damaged children in the pre-school and school age group.

2. 61% of families served by one family agency in Toronto had economic problems and 75% had difficulties in family relationships and personal adjustments.

3. alcoholism, with or without psychosis, was the second leading cause of first admissions to mental hospitals for young adults in 1958.

One of the major problems facing social agencies is the need to provide day care centres for pre-school children, and lunch time and after school care for the older children of working mothers. In Ontario, 15% of all women (14 years of age and over) are married workers. It is estimated that about half of the married women who are employed have dependent children.

Deaths in the younger adult years are due to: accidental causes (64%); diseases of the heart; and cancer. Suicide and self-inflicted injuries account for 1 out of every 20 deaths.

The most common illnesses are again the common cold and influenza, followed by headache and symptoms referable to the limbs and back.

The greatest number of complaint days are attributed to diseases of the respiratory system; headache; and diseases of the digestive and circulatory systems. It is interesting to note that although diseases of the circulatory system contribute only 2% of the illnesses, these diseases cause 9.8% of the days of illness. This is a high proportion of days of illness to number of illnesses.

Diseases of the digestive system compete with normal delivery and complications of pregnancy as the chief reason for admissions to, and days of care in hospital. Accidents plus dis-

eases of the genito-urinary system are other important reasons for hospital admissions.

Ontario mental institutions report that 47% of the young adults on their books are suffering from schizophrenic disorders and 28% are mentally deficient.

It seems then, that the major health problems for 25 to 44 year olds are:

- diseases of the circulatory system
- accidents, poisoning and violence
- cancer
- diseases of the digestive system
- complications of pregnancy
- schizophrenic disorders
- mental deficiency
- alcoholism
- marital problems related to financial difficulties and the rearing of children:
- and for the single individual — potential social isolation.

Problems of Middle Age

"A recent study of marital happiness in the United States revealed that the forties and early fifties is the crisis period for married women and the fifties are critical for men."*

For women, the major problem was their joblessness when children no longer needed mothering. For men, the main problems stemmed from occupational rather than family life.

In the United States 1 out of every 10 marriages breaks up after the twentieth year of marriage.** Corresponding figures are not available in Canada.

An occupational problem receiving much attention at present is the question of the unemployed person who, despite skill and ability, is not hired because he is "too old." A 1959 pamphlet entitled "How Old is Old?" published by the Unemployment Insurance Commission states, "Employment barriers apply not only to applicants 60 years of age and over, but also to those in the 40-plus age group." One of the reasons given for this employment problem is that pension plans do not permit the hiring of anyone in the 45-plus age group.

Mortality figures for the middle years show that 42% die from diseases

*Bassard, J. A. S. & Boll, E. S. "Mental Unhappiness in the Life Cycle."

**Duvall, E. M. *Family Development*, Lippincott, New York, 1957.

of the heart; 24% from cancer; and 14% from vascular lesions of the central nervous system; with accidents occupying a much less prominent place.

The greatest number of cases and days of care in hospitals relate to diseases of the circulatory system, with diseases of the digestive system as a second cause.

For those 45-64 years of age, diseases of the respiratory system, of the circulatory system, and of the bones and organs of movement contribute almost equally to the total number of complaint days. While the common cold and influenza still cause 40% of the illnesses, headache, arthritis and rheumatism cause an additional 11% for the middle-aged adult.

In this age group, 50% of persons in mental hospitals are there because of schizophrenia; mental deficiency and manic-depressive reactions account for another 20%.

For this age group — 45 to 64 years—the major health problems are:

- diseases of the circulatory system
- cancer
- diseases of the respiratory system
- rheumatism and arthritis
- schizophrenic disorders
- mental deficiency
- manic-depressive reactions
- the joblessness of women when children become independent
- occupational adjustments for men, plus the threat of unemployment.

The Old Age Group

"The number of persons in Ontario in the age group 65 and over is now approaching half a million and is increasing at the rate of 10,000 per year. In 1960, 1 out of every 12 persons in Ontario was in this older age group."

In an article in *Focus*, a Social Planning Council publication, the following statement was made:

Older persons have problems — major problems include finances, living arrangements, health, and the ever-present problem of making new social adjustments to changing family situations.

At least 40% and perhaps as high as 60% of Ontario's population, 65 and over, do not have incomes of an adequate budget level. The 1956 census showed that 45,000 old people were living alone — two-thirds of these were women. Indications are that

many of these are roomers or lodgers in urban centres. Approximately 20,000 aged persons live in various institutions including hospitals for the mentally ill, hospitals for the chronically ill and homes for the aged.

The admission rate to mental hospitals is twice that of any other age group. Of all first admissions in this age group 80% are patients with senile psychosis or psychotics with cerebral arteriosclerosis.

It has been said that "The chronic diseases, the diseases and conditions which attack middle-aged and elderly people, are our major health problems of today."* In the population as a whole, the severe and total disability rate is 30 per 1,000; at ages 65 and over severe and total disability cases are estimated at 150 per 1,000 — 5 times as many.

The greatest number of complaint days for those over 65 are contributed by diseases of the circulatory system; diseases of the bones and organs of movement (primarily rheumatism and arthritis); symptoms of senility and ill-defined conditions; and respiratory diseases. Although the common cold and influenza still cause the greatest number of illnesses, the percentage has decreased steadily over the years from 50% in children to 34% in the old age group.

Deaths are due to cardiovascular disorders, 62%; cancer, 15%; pneumonia, bronchitis and influenza, 5%.

The greatest number of hospital days for older people are due to circulatory disorders; accidents, poisoning and violence; neoplasms; and disorders of the nervous system and sense organs.

The major health problems of old people then are:

- inadequate finances
- inadequate housing
- diseases of the cardiovascular system
- senility
- cancer
- arthritis and rheumatism.

Summary

Particular problems have appeared again and again throughout all age

*A. H. Sellers, "The Lengthening Life Span." Address presented at the Tenth Annual meeting of the Ontario Public Health Association, September 1959.

groups. Accidents, poisoning and violence — particularly motor vehicle accidents — are leading causes of death and illness in all age groups.

Cancer is a leading cause of death for all ages.

Mental deficiency and epilepsy handicap many.

The common cold and influenza cause more generalized misery than any other disease.

Cardiovascular diseases are not only the leading causes of death over age 35 but also account for much of the chronic illness.

Inadequate family relationships and

inadequate personal adjustments are problems for many persons.

Unemployment and financial problems affect all age groups.

Insufficient education is becoming an increasingly great handicap.

The awareness of problems such as these is not of value in itself. The value lies in the way in which this knowledge is used as a guide to intelligent action. To the nursing profession this means the identification of the nursing needs associated with these problems and the planning of nursing service and nursing education to meet these needs.

MEETING PATIENTS' NEEDS

MOYRA ALLEN, M.A., B.N.

What factors must be considered in the development of nursing education programs to prepare personnel to meet nursing needs which arise from existing health problems?

This Changing World

WE ARE attempting to meet nursing needs in a society in ferment, one in which change is the characteristic of the day. In our complicated social structure the day of the individual entrepreneur is past. The needs of society are being met through more and more complex institutions and highly organized services. It is difficult to work alone. We work in groups, not only with our own colleagues but with members of other professions and occupations. The neat little triangle of nurse, patient and doctor has ceased to exist. No longer is the means of communication direct or the organization simple.

The whole structure for the provision of health services is changing. It is impossible now for any service to operate independently. We recognize that hospitals and public health agencies must plan together to provide for the integration of community health services. In addition, the nature of the hospital is undergoing change to meet the demands of the public for ever-increasing services. The centre of medical practice is the hospital. It has

become almost impossible for the doctor to practise without its services. The hospital, in its efforts to meet the demands of the public and the medical profession, is facing reorganization. This reorganization must consider the cost and the kind of services to be provided. In assessing its responsibility to the community, the hospital is trying out new plans with emphasis on outpatient clinics, home care and referral programs, progressive care units, and special units for chronic illness.

The hospital is now closer to the community it serves than ever before, since every citizen is paying for its upkeep. This leads the community to ask: How can we pay the cost of modern medical care? How much responsibility rests with provincial and federal governments? How much responsibility rests with the family? Are we institutionalizing too many people?

Change and Nursing

Nursing cannot isolate itself from the total needs of the community. The preparation of professional workers and the service they give are a part

of the total development of society. This means that nurses must enlarge the main study of their special field with an awareness that encompasses local, national and international affairs — education, unemployment, civil liberties, crime and delinquency. In other words, health cannot be developed at the expense of education, welfare and other social services, but as part of the harmonious development of all services. This is, in fact, the aim of all professions — the comprehensive improvement of the total society. Ralph Tyler, the noted authority on education in the United States, has described this as the final step in achieving professionalization.

If we reflect on this idea we see that nursing is a part of the joint attack by many groups of workers on the practical problems confronting the health field. Robert Oppenheimer has said, "this is in essence an attack on the human problem; the problem of understanding man and his relationship with his fellow man." This statement has extremely broad implications. In nursing we cannot expect to prepare all of our co-workers to view the situation in such a broad perspective. What we need is a group of well-prepared leaders who have this vision, who are ready to take part in the development of social policy. We need nurses who can work with governments, with other professions and with the public. There is urgent need to study the complex problems in the health field and to evolve new patterns for the provision of health services.

We need better-prepared administrators in our hospitals to plan and organize nursing services. This does not mean only directors of nursing but supervisors and head nurses as well. We need nurses with imagination in the public health field to discover how public health services can be more closely linked with the diagnostic and treatment services of the hospital. We are in desperate need of teachers with comprehensive vision to direct our educational programs. We have gained tremendous knowledge and insight into how to give good nursing care, but we do not have the teachers or the organization to realize our concept in general practice. We have more students in schools of nursing than ever

before, and we have one of the highest ratios of nurses to population in the world. We have planned programs to introduce various groups of assisting personnel, but we have not yet learned to use them to advantage. We *should* be in an advantageous position to give our people the very best that the nursing profession can offer. The question is, how can we achieve the best? This is our problem.

The Framework of Theory

The solution to the problem lies in nursing education. We must accept the fact that we are living in a changing world. No longer will the habit formations of today be effective for the nurse of tomorrow. Nurses must be able to cope with change and to initiate change. These characteristics can only be developed through the kind of education that allows the student to analyse situations from what might be called a "framework of theory." What is this framework? It is what educators call a liberal education. Robert Henle has described liberal education. He says:

In liberal education we try to bring out the human traits, the rationality and the freedom, the imagination and the warmth, the understanding and sympathy that are native to our nature, but need cultivation, encouragement and discipline.

This encouragement and discipline come from a study of the situations in which man has found himself and of the factors which have influenced his beliefs and his actions. This framework enables the student to view a situation in perspective and to make a sound analysis of the factors involved in the situation she faces. In other words, this framework of theory shapes the direction of her action.

We do not have enough nurses with a liberal education. This has arisen because nursing education has been centred in hospitals. If we expect to meet our needs for administrators, supervisors and educators, we must look to the universities to give this broad education. If we had sufficient persons with this kind of preparation we could improve the quality of programs in schools of nursing greatly.

As health problems and health services change, so does nursing. As we

learn more about man we are constantly finding better ways to meet his nursing needs. It is essential that nurses should be able to look at situations as they exist in the present, and to use new knowledge appropriately. This is accomplished by the use of the problem-solving approach in nursing situations; by developing nursing skills, manual, technical and interpersonal, and by accomplishing the purposes of nursing through the supportive and healing roles. How do we go about teaching this kind of nursing, and how would the curriculum be developed?

As most schools of nursing are in hospitals, it is inevitable that students learn to nurse sick people first. It is in this first nursing experience that the foundation is laid for solving nursing problems at any level. For this reason the first nursing course is the most important one in the curriculum. Traditional approaches in education do not seem to meet the need and, if they are used in the beginning, change is almost impossible later.

In hospital schools the aim of the first nursing course is usually to help the student assist the patient with those simple human needs that he is unable to meet himself. Human needs are classified as physiological: nutrition, activity and exercise, rest and sleep, comfort; and psychological and social: the need to belong, to feel worthy as a person, to have security. Now let us clarify the main ideas that the student begins to comprehend:

1. That the problem-solving approach is the method of nursing.
2. That basic needs are the same for all people, but that they are expressed differently in each individual.
3. That attitudes toward health and health habits are learned within the culture and therefore differ from one culture to another.

Early Experience

How might the first nursing course be taught? When the student enters the school she is vitally interested in helping people. She has a warm, friendly manner and is spontaneous in her responses. Let us capitalize on these attributes and permit the student to be with patients as quickly as possible. Give her the opportunity to

spend some time with a patient doing a few simple things that she is able to do. In this way we take care of *her* needs as well as the patient's. It is important that the student share her first discoveries in nursing with her classmates and with her instructor. This first phase of education is spoken of as the "stage of romance" by Alfred North Whitehead. By this he means the joy and sense of discovery which comes when one has had a first glimpse of some new and great adventure. This is an adventure to the new student. It is an important phase because out of it comes the direction for more precise learning. Thus, it is an educational experience and the instructor needs to be part of it. Group conferences provide the medium for communication between the students and the instructor, and create motivation for further learning.

In group discussion the student can identify the simple needs of her patient and suggest some ways of meeting them. This is a first-level understanding of meeting patients' needs, but it is on this foundation that we build. Gradually, from the observations that each student contributes, the group clarifies the basic needs of all people. The instructor and the students together can build a theory of needs that will form a basis for all nursing. As the student studies physiology, bacteriology, sociology, growth and development, she will gain more knowledge from which to draw in meeting the patient's needs. Thus, from the beginning, emphasis is placed on observation; on using observations to assess needs; on finding ways to meet these needs and on assessing the results. This is problem-solving.

As the student identifies the particular needs of her patient, it becomes obvious that she must develop some skills to meet them. To be consistent we must use a problem-solving approach in teaching procedure, once the purpose of a procedure or a group of procedures is established, the instructor and the students together can work out the basic principles. The students can suggest the equipment needed to accomplish the purpose and the important factors to consider in performing the procedure. Following this discussion it seems valuable for

the instructor to demonstrate one method of doing the procedure because she is a person who displays great skill. This helps the student to appreciate the art involved in manual skill. The student needs an opportunity to handle equipment and to practise the procedure. She may find better ways to do parts of the procedure herself but she should practice to gain skill in the various movements. As she carries out the procedure for her patient, she continues to discover ways of modifying it to meet his needs. As David Gordon says "the object of technique is to serve the purpose of creation."

In group sessions the student is helped to recognize that her patient's background and environment have shaped his ideas on health. She begins to understand that concepts of health and ways of remaining healthy differ greatly. This acts as a stimulus for her to comprehend the patient situation within its wider context. The instructor makes use of the student's ideas about health to show that attitudes toward health and illness are basic to a culture and that they are not easily modified. Many studies have been done which are helpful in developing this idea, for example, "Health of Regionville" and "My Name Is Legion."

Throughout the first nursing course the problem-solving method is demonstrated best in group conferences. Each student describes her nursing action in terms of her assessment. The instructor and the students pick up relevant observations that the student makes. They examine and clarify the implications of these observations for the nursing plan. The instructor encourages the student to think of a variety of approaches to meet her patient's needs. This is the core of the problem-solving approach.

Prerequisites

If the student is to learn nursing in this fashion there are certain requirements. These are: continuity of assignment, freedom within the situation, time and security. For the student to know her patient and to realize that nursing improves as she gains more insight into his needs, it is essential that she should have the same patient over a period of time. When students change patients frequently

they only learn to do procedures. Nursing then becomes task-centred. If we wish the student to centre care around the patient, she must have continuity in her assignments. This does *not* mean that the young student should have the same patient over a period of weeks. At this early stage she does not have the background in interpersonal relations or in health to make a long experience meaningful. However, in a continuous assignment for a relatively short period she can observe her patient's state of comfort and well-being and see herself as a positive or negative influence on his state of health. For example, in the beginning she may see herself as a positive force simply by noting that a patient seems to like having her around, or that the patient indicates that she feels better after the student cares for her.

If the student is to use a problem-solving approach in developing a plan of nursing, she must have freedom to do so. This implies that she is not told specifically what to do. She learns that there are sources of information which must be considered, for example, the patient's chart, the nursing Kardex. With this material, plus her own observations, she works out her plan. She learns to use the instructor effectively, as a person who can facilitate learning. The instructor asks appropriate questions; helps the student to clarify ideas; gives assistance when difficulties arise. The area of action in which the student has freedom is limited. Both she and the ward staff need to know the limitations with reference to what she can do. A large amount of freedom should be permitted in the group conferences, so that the student will have freedom to think and to try out ideas within the group. Actually, freedom to think is of primary importance.

Another important consideration is time. To reflect on one's observations, to think about ways of meeting needs, to examine alternative plans and to come to a decision — all of these take time. As George E. Geiger, professor of philosophy at Antioch College, said, "delayed reaction is the most characteristically human of all attributes, the very differential which helps to define man." Of course, as the student becomes more skilled, she takes less time.

At each level of her development we can expect keener observation and deeper insights, but time is always important.

The student can proceed in learning nursing only if she feels secure in her environment. If not, she will learn an accepted habit pattern to prevent making mistakes. Unfortunately, the ward situation can be a place of great insecurity. Tension is high since there is a time element in the work situation. Students readily develop habit patterns to protect themselves from blame and criticism. How does the student gain a sense of security? It is attained primarily through the relationship between teacher and student. The teacher in her authoritarian role gives responsibility and support. This enables the student to test her ideas and to clarify her problems. The good teacher is consistent in her approach. She individualizes her teaching so that the student gains a feeling of worth and security. Moreover, the good teacher defines the area of activity so that the situation itself creates security. With each new experience in nursing the student may regress and become more dependent on the teacher, but as she gains confidence in a number of situations within the experience this dependence should diminish.

Just as the student needs time with her patients, so the teacher needs time with the students. It is only as she understands a student that she is able to analyse her progress, identify barriers to learning, and help her to overcome these. Despite service obligations, schools of nursing usually have control of the student's time and experience during the preclinical period. This is an opportunity to plan for a worthwhile nursing experience. To do so, each instructor must have a small group of students in the ward over a period of time. This is becoming more possible since the number of clinical instructors is increasing and nursing instruction can be centred in the ward rather than in the classroom.

The Theory of Disease

As the student progresses from the first nursing course, she gives more consideration to the illness of the patient. Now she needs to learn the theory

of disease. This theory includes a basic understanding of the fundamental disease processes such as inflammation, neoplasm, trauma, congenital anomalies, metabolic and degenerative conditions and psychosocial disorders. These disease processes should be taught in such a way that the student sees similar elements in disease manifestations. This emphasizes the fact that every condition is not a different disease entity. The student learns that the process of inflammation is the same wherever it occurs in the body but that the signs and symptoms are modified according to the location of the process and the individual's response to his illness. She discovers that the ideas basic to diagnosis and treatment are the same, although the particular procedures and techniques may vary. As she nurses patients with common inflammatory diseases, for example, gastrointestinal infections, pneumonia or arthritis, she will acquire ability to apply principles from one situation to the next.

Selecting Experiences

What are the implications that a study of health problems has for the selection of learning experiences in the curriculum and for the rotation plan? There are certain health problems which occur frequently in each age group. These determine the experiences that the student should have. It is not necessary for her to care for patients with a wide range of diseases. With her framework of theory and her increasing knowledge of the sciences, she needs opportunity to nurse selected patients with health problems prevalent in the community. In this way she will become more skillful in meeting total needs.

It is well known that basic needs are modified in each age group. The needs of the particular age group plus the specific demands arising from the health problem, become the foundation for the clinical teaching program. The following examples demonstrate this point.

1. The Ill Child in Hospital

(a) *Modifications in common human needs:*

deviation in the normal developmental process,
adjustment to new situations

— the hospital,
alteration in family relations,
separation from family,
general needs — nutrition, hygiene, rest and sleep, play and activity, safety, contact with family.

- (b) *Needs which derive from the health problem* such as a gastrointestinal infection in a baby:
malnutrition,
dehydration,
electrolyte imbalance,
care of the skin,
prevention of spread of infection.

2. The Aged Person in Hospital

- (a) *Modifications in common human needs:*

impaired physiological functioning,
disturbance of memory for recent events,
concern with the future,
changes in motivation,
need to be independent.

- (b) *Needs which derive from the health problem*, for example, a cerebrovascular accident:

unconsciousness,
paralysis,
dehydration,
fever,
incontinence,
problems derived from bed rest and inactivity,
aphasia,
rehabilitation.

The students and instructor together can work out the individual needs of each age group and the specific needs due to the health problem. If more knowledge is necessary, the student should have the opportunity to discover it for herself. It is in the care of patients that the student observes modifications of these needs and plans to meet them appropriately.

To recapitulate, the development of a rotation plan is determined by the experiences which are selected to assist the student to nurse patients with health problems which are common in our society. These occur in different age groups, both inside and outside the hospital. The extent to which these experiences are available, both in the hospital and in the public health field, will determine the breadth of

preparation of the student. Within each selected experience the student needs time with the patient or the family and, therefore, the emphasis is on continuity of assignment.

Complex Aspects

If we think of the process of learning nursing as a continuum, then we can visualize the student as making progress in the various aspects of nursing from the day the program begins until it is completed. Three complex aspects of nursing enter into the picture.

The development of interpersonal relationships might be considered first. As new theory in the social sciences, in human relations and in psychiatry is added to the curriculum, the scope of the student's observations increases to include the patient's total behavior. His behavior becomes more meaningful as she views it within his life pattern. She begins to examine her relation with the patient and to see her role as an important factor in furthering his progress. From her framework of theory she individualizes her role in relation to the patient's needs. In the care of the acutely ill patient it is vital that she should establish a valuable relationship quickly as the average patient-stay is approximately 11 days.

During her experience the student will nurse patients with chronic illness. This is an excellent opportunity to emphasize that hospitalization is only one phase in the patient's illness. The teacher can help the student to comprehend the patient situation in its broadest context so that she can assist the patient to move from a state of dependence to independence. Rehabilitation usually begins in a simple fashion in hospital. The first step, when the patient is acutely ill, might be to permit him to make the decision as to the time of his bath. Later, the student may allow him the time to do whatever part of his care that he can, even if it is only taking the cloth to try to wash his face. A student needs considerable support from her instructor in such care since it takes more time to nurse the patient and progress is so slow that she is apt to become discouraged. It may not be possible for the student to care for patients with

chronic illnesses in their homes. However, she has a framework of theory and a point of view about rehabilitation nursing which guides the nursing action that she plans for the patient in hospital and which the patient and his family may carry over to the home.

The Nursing Assistant

One of our greatest problems in nursing is to use nursing assistant personnel to advantage. If nurses are to work with nursing assistants they must learn how to do so. This experience should become an important part of the educational program. The professional nurse operates from a framework of theory. She is able to come to decisions on the basis of her assessment. Within the plan of nursing for the patient, there are particular duties that can be carried out by workers with less preparation. The nursing assistant uses judgment in special limited areas and carries out a variety of manual and technical skills. As she comes to know her patients, she needs opportunity to describe her observations so that they may be considered in the over-all assessment of the patient and in the development of his plan of care.

The student nurse must know the area of activity of the nursing assistant. She must have experience in providing opportunities for her to take part in making a nursing care plan; for integrating the care given into the total plan.

The Instructor as Consultant

The role of the clinical instructor in the first nursing course has been considered. What is her function in the remainder of the program?

The role of the instructor changes as the student progresses. When the latter has a greater background of theory and has developed the basic skills, supervision becomes less direct. Although the student continues to use the problem-solving approach in nursing, she does so more independently. The instructor is used primarily as a consultant. The student also will be able to use other sources of information more readily, for example, text and reference books, journals, and the personnel of the ward. It is not that supervision decreases, but that the

character of supervision changes.

Curriculum Planning

Teaching nursing in this way requires planning by the total staff for the entire curriculum. Rigid, isolated course outlines are of no value. As the nursing instructors cope with the learning problems of students in clinical situations, it is essential that they should meet together to find ways of solving them. Because the effectiveness of the educational program depends on the quality of nursing service in the hospital, key persons from nursing service are needed every step of the way in planning the curriculum.

Conclusion

We can do much to improve the quality of nursing care through our educational program. The four aspects of this improved program deal with the importance of a liberal education to create a framework of theory which is fundamental to good education in a society where the most notable feature is change. Margaret Mead has said,

We are now at the point where we must educate people in what nobody knew yesterday, and prepare people in our schools for what no one knows yet, but what some people must know tomorrow.

We must use this liberal education effectively in liberating the potential of our nursing students through the problem-solving method of teaching. We must base our curriculum on the health problems of the community. Finally, our curriculum must consider the most effective means of educating nurses to work with assistant nursing personnel.

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In Memoriam

Ada Emily (Chapman) Anderson, a graduate of a hospital in England, died in Fort Frances, Ont. early in 1962. She was a past president of Chapter 10, RNAO.

* * *

Florella May (Stevenson) Arnot (Toronto General Hospital, '14) died in Toronto. At the time of her graduation she was the winner of the R. L. Patterson prize for attaining the highest standing in her class.

* * *

The Alumni Association of St. Paul's School of Nursing, Saskatoon has announced the decease of several graduates in recent months. Tribute is paid to the memory of: **Ingar (Sherven) Bryden** '16; **Alta May (Garrison) Causgrove** '19; **Dorothy (Buck) Croteau** '33; **Helen (Reed) Ellis** '37; **Helen (Slattery) Rutherford** '45; **Louise (Trotter) Stillborn** '51; **Lorraine (Dubord) Blair** '51.

* * *

Annie Isabel Browne (Toronto General Hospital '95) died in Toronto early this year. Miss Browne did private duty for many years and continued to take an active interest in the affairs of her alumnae association until shortly before her death. A member of the RNAO for 20 years, she retired from active nursing in 1946.

* * *

The Alumnae Association of the Montreal General Hospital has announced the death of several members. Tribute is paid to the memory of: **Joyce (McWilliams) Bush** '49; **E. Lillian Dickie** '10; **M. L. MacDermott** '11.

* * *

Helen Isabel Campbell (Vancouver General Hospital '11) died in Vancouver recently. She was in her 85th year.

* * *

Priscilla Campbell (Royal Victoria Hospital, Barrie, Ont. '16) died on February 4,



PRISCILLA CAMPBELL

1962 in Chatham, Ont. Miss Campbell was the administrator of Chatham General Hospital, Ont. for 35 years until her retirement in 1957. In 1935 she was presented with a service medal by Their Majesties, the late King George V and Queen Mary.

Prior to her appointment in Chatham, Miss Campbell was superintendent of Brockville General Hospital for a two-year term. This post had succeeded experience as a ward supervisor, a night supervisor and operating room supervisor. Her efficiency, her devotion to her work and her capabilities brought many honors throughout her career. In 1924 she was made a charter member of the Ontario Hospital Association. She became OHA president in 1947. In 1925 she became a member of the American Hospital Association and in 1950 the AHA granted her one of its few life memberships. In 1942 she became a member of the American College of Hospital Administration.

In 1945 Miss Campbell was named charter president of the Regional Hospital Council, Districts 1 and 2. In 1954 she was one of two women appointed to the Dominion Council of

Health for a set term of membership representing Canadian women's organizations. In addition to these many professional appointments Miss Campbell was a charter member and a past president of the city's Zonta Club.

To be a nurse had been her one great ambition as a young girl. She served her profession well and generously, in particular the hospital with which her name was associated for so many years. Due largely to Miss Campbell's guidance, planning, imagination and her refusal to become disheartened in the face of difficulties, the Chatham General Hospital grew from 65 beds in 1922 to 300 beds with the completion of its sixth and most recent addition which occurred after her retirement.

* * *

Rose Ida (Gratton) Courteau (Ste Justine Hospital, Montreal '38) died recently as the result of an accident. She was employed in the health unit of the Dominion Bridge Company, Montreal.

* * *

Doris (Carruthers) Currie (Ottawa Civic Hospital '36) died in Charlottetown, P.E.I. She had engaged in private nursing in Prince Edward Island for the past 10 years.

* * *

Christine Claire (McDonald) Donahoe (Victoria General Hospital, Halifax) died in Montreal early in January. She was extremely interested in welfare work and was a member of St. Mary's Hospital auxiliary in Montreal.

* * *

Reta Margaret (MacLean) Doucette (Newport Hospital, Newport, R.I. '27) died in Toronto. She had engaged in institutional nursing and had served in Canada and overseas with the RCAMC, 1942-45.

* * *

Phoebe (Coborn) Forge (Riverdale Isolation Hospital, Toronto '18) died late in 1961 in Toronto.

* * *

Janet (MacHattie) Goard (Mack Training School, St. Catharines, Ont. '06) died in Lindsay, Ont. late last December.

* * *

Harriet Jane (Barber) Graham (Winnipeg General Hospital '90) died in Winnipeg early this year. She had been retired from nursing for many years.

* * *

Fernande Harel (Hôpital St. Joseph de Lachine) died early this year. She was engaged in public health nursing.

* * *

Eva Marguerite (McKay) Hibbert (Regina Grey Nuns' Hospital '30) died re-

cently. She was the matron at the Department of Indian Affairs hospital in Pine Falls, Manitoba at the time of her death.

* * *

Mary Rebecca (Henderson) Higgins (Kelowna General Hospital, B.C. '33) died late last year.

* * *

Teresa C. Huntley (St. Michael's Hospital, Toronto '21) died in Toronto early in 1962.

* * *

Renée Jaton, editor of the French section of *Revue Suisse des infirmières* since 1953, died suddenly in December 1961.

* * *

Marjorie Emma (Spencer) Jeffrey (Ottawa Civic Hospital '47) died late in December 1961. She had engaged in private nursing.

* * *

Jessie (Snider) Jenkins (Winnipeg General Hospital '22) died late in 1961. She had been retired from active nursing for many years.

* * *

Isabelle M. Johnston (Lowell General Hospital, Mass.; Women's Hospital, New York) died recently in Prince Edward Island. She had retired from nursing about 10 years ago after several years of work in Toronto where she specialized in pediatrics.

* * *

Alice Flora Keith (Royal Alexandra Hospital, Edmonton '19) died in Vermilion, Alta. early in December 1961. She was matron of the Vermilion Hospital for 33 years, retiring from active nursing in 1956.

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Fredericka Louise (Ferguson) McAvoy (Kingston General Hospital '28) died after a short illness. She had engaged in private nursing during her professional life.

* * *

Cora Victoria McEachern (Strathcona Hospital, Edmonton '09) died recently. She was the first graduate of this hospital which was the forerunner of the present University Hospital.

* * *

Evelyn C. Mooney (Fifth Avenue Doctors' Hospital, New York) died in Saint John, N.B. after a long illness. She was the assistant matron of Lancaster D.V.A. Hospital, Lancaster, N.B.

* * *

Theodora Miriam (Hopkins) Morison (Vancouver General Hospital '32) died early in 1962.

(Continued on page 353)

PREVENTION OF CONTRACTURES AND DECUBITI

OLGA D. WOLENSKI

The concept that contractures and pressure sores are an inevitable result of bed rest is a thing of the past. However, the fact that these conditions are frequently seen in hospitals suggests that insufficient attention is paid to practising those techniques necessary to prevent these evils. This article is concerned with describing techniques that have been found satisfactory in practice in the prevention of these problems.

Prevention by Mobilization

ANY JOINT that has been immobilized in one position will eventually become fixed in that position. Even healthy individuals, placed on complete bed rest, will show restriction of the range of movement of joints unless special efforts are made to prevent it. Active, normal range of movement at all joints will prevent contractures.

In many patients, the nature of the disease itself may produce impaired movement, or the treatment required for the disease may necessitate immobilization that may result in impaired movement. In either case, positive measures must be taken to prevent long continued (more than 24 hours) immobility of a joint, unless this is essential in the treatment of the condition. Impaired movement may be the result of:

- Disorders of joints, such as rheumatoid arthritis;

- disorders of muscles, such as muscular dystrophy;

- disorders of nerves, such as polyneuritis or poliomyelitis;

- disorders of the central nervous system, such as cerebrovascular accidents, multiple sclerosis, and spinal cord injuries.

In the arthritic group, the patient must be instructed in a program to encourage active normal range exercises as far as possible. In the paralytic, active normal range of movement may be impossible for the patient to accomplish. Here, the nurse and the physiotherapist, at least once and preferably twice daily, must move the paralyzed joint through a full range of movement. Many of these patients will be on an active physiotherapy program

designed to maintain or increase their mobility. Frequently nurses consider that joint range should be of no concern to them, that it is entirely a physiotherapist's responsibility. But even where excellent physiotherapy is available, the results obtained from treatment may be completely nullified by indifferent nursing. This is particularly obvious in those patients with spastic paralysis, such as cerebrovascular accidents with hemiplegia, multiple sclerosis, and also in those patients where pain and muscle spasm is an important factor, such as peri-arthritis of the shoulder or poliomyelitis. In these conditions, the spasm of the affected muscle tends to hold the joint in one position. It is the physiotherapist's responsibility, by use of stretching and passive movements, to try to counteract the effect of the spastic muscle and to restore the normal range of motion in the joint. It is the nurse's responsibility to see that the range obtained by the physiotherapist is maintained by correct positioning and adequate splintage. The hour of the physiotherapist's time that is spent increasing the range of movement is wasted if, for the next 23 hours, the spastic muscle is allowed to act unopposed due to inadequate nursing care.

Disorders requiring immobilization as part of their treatment include such conditions as fractures and tendon transplants. Under these circumstances, mobilization is directed towards preventing contractures occurring at all those joints not immobilized by casts or other means of fixation.

Prevention by Positioning

Each doctor and each physiotherapist



Standard back-lying position

pist has his own particular method of positioning limbs to prevent contractures. The nurse must learn the positions required then ensure that these are maintained during the entire time that the patient is on the ward. A standard back-lying position (*Fig. 1*) for quadriplegic patients, with restricted abduction at the shoulder and weak hands, has been found useful on the Rehabilitation Ward at the University of Alberta Hospital. Important features are:

Independent foot boards: These allow positioning of the legs in abduction to counteract spasm in adductors and to relax the abductor muscles. It permits use of the foot board when the supine patient is positioned with knees and hips flexed, and also when one leg is shorter than the other. Spaces are provided under the heels and both malleoli to prevent pressure sores on these areas. A small adjustable wedge is available on the bottom of the board to allow wedging of the foot, thus preventing lateral rotation of the foot and leg. The part of the foot board behind the calf is short enough to allow flexion of the knee, yet long enough to provide stability to the foot board by the weight of the leg on it. With this type of foot board

it has been found possible to stabilize the ankle and mid-tarsal joints in anatomical position, and also to control movements of rotation and abduction at the hip without any ancillary devices such as bed cradles and sand bags.

Shoes: All patients with paretic feet wear shoes to provide stability for the longitudinal and transverse arches.

Knee pillow: This produces just enough flexion, 5-10 degrees, to prevent genu recurvatum and counteract hamstring spasm in the acute phase of poliomyelitis.

Lumbar pillow: This is used to prevent loss of normal lumbar lordosis, relax extensor spasm. It is also useful in turning patients. (See below).

Abduction board: This board permits any degree of abduction and rotation at the shoulder. It is used routinely on all patients with deltoid paralysis.

Elbow, forearm, wrist and hand splint: This is a plastic splint attached to the abduction board by a sliding wing nut. It allows complete control of elbow flexion and extension. It maintains a neutral position of the forearm and wrist and a functional position of the fingers and thumb.

In the side-lying position (*Fig. 2*), the lower leg remains extended at hip



Side-lying position

and knee while the upper leg is flexed at 90 degrees at both hip and knee. It is supported by two firm pillows that hold in place a simple right angle foot-board which provides a firm support for the foot. In this position the lumbar pillow is placed in the hollow in the flank between pelvis and thorax and prevents any tendency to scoliosis. The patient is supported by another pillow in the small of the back to prevent him from rolling over to his back. There are many variants in detail of these two basic positions, (Fig. 3) where, because of pain, spasm or instability, the patient needs to have his legs more closely approximated.



Variation is possible

Routine use of these basic positions will help prevent the onset of many serious and unnecessary contractures in patients with strokes, poliomyelitis, spinal cord injuries or any other conditions that confine them to bed for long periods of time.

Prevention of Pressure Sores

Although, in the majority of conditions, a pressure sore is considered a sign of poor nursing, there are many

nurses who firmly believe that pressure sores are inevitable in patients with a combination of paralysis and loss of sensation, such as occurs in spinal cord injuries. A four months' study tour* of Spinal Injury Units in Great Britain provided convincing evidence that, even in the most severe conditions, *good nursing will always prevent pressure sores*. Therefore, the presence of a pressure sore should be regarded as a sign of inadequate and/or incompetent nursing.

Dr. L. Guttman, director of Stoke Mandeville Spinal Injury Unit says: "Where there is no pressure, there will be no sore." This seems so obvious that its significance is frequently overlooked. The significance is that pressure sores can only occur if there is prolonged pressure over bony prominences. Frequent, regular turnings, at least once in every two hours, is the simplest method of avoiding pressure over any area.

Normally, side-lying, alternating on the right and left side, is the most satisfactory way to change position but back-lying and sitting can be used as variants during the day and particularly at meal time.

The following technique is used in turning patients in the Rehabilitation Ward of the University of Alberta Hospital. It is a modification of the technique used at Dr. Hardy's Spinal Injury Unit at Lodge Moor in Sheffield, England.

Turning patients by means of a lumbar pillow: The object in using the lumbar pillow is to turn the patient with complete safety and comfort and with greatest ease to the nurses. The patient is lifted, rolled, and positioned in good alignment. Ideally this is done by three nurses for low spinal lesions, four for high spinal, but two and three can manage adequately. The patient does not assist in the procedure, but has his arms folded on his chest.

Two nurses stand on the side of the bed to which the patient will be facing with one nurse on the opposite side (Fig. 4). The first move is to shift the

*This tour was made possible by a nursing research grant from the Alberta Polio Foundation that was made available to the Rehabilitation Unit, University of Alberta Hospital, Edmonton.

patient to the side away from the side he will be facing. He is then rolled on his side by pulling the lumbar pillow taut. This is done by the two nurses who stand opposite each other. The third nurse lifts and moves the patient's legs, at the same time maintaining good alignment. When only two nurses are available to turn the patient, his legs are first moved over to the side of the bed opposite to that which he will be facing, before any pull is put on the lumbar pillow. As soon as the patient is in position his bony prominences are inspected. A second pillow is used to support the lumbar pillow (Fig. 5). The patient's legs are positioned in the standard side-lying position described above (Fig. 2).

At the end of two hours, the same procedure is repeated in reverse. The



Turning a patient

Note-taking is essential to remembering. Two Los Angeles psychiatrists found that the memory recall of psychiatric residents, two days after a psychotherapy session with a patient, dropped to 13-18 per cent when notes were not referred to and rose to 26 per cent when they were. A startlingly low recall — two per cent — resulted when memory alone was used, when no notes were taken during the session.

The conclusions of the report state: 1) note-taking is essential to increased recall; 2) no note-taking results in almost total forgetting; 3) over 80 per cent of the relevant information in a therapy hour is forgotten in one to two days; 4) this increases to over 90 per cent in seven days.

Though intended for application in psychiatry, these findings seem applicable to everyone who would increase his memory powers, raise his capacity for retention.

— Squibb Nurses Notes, 10:4

patient is lifted and rolled on to his other side. This is continued throughout the 24 hours.



The use of pillows

Conclusion

Contractures and pressure sores are signs of poor nursing. These conditions can be prevented by the use of the nursing techniques described. It is up to us to preserve the escutcheon of nursing, unsullied by such blots as these. The challenge is ours.

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At Lower Caraqueet, New Brunswick, 17 men signed up for the home nursing course to be taught by volunteers of the Red Cross branch. They will learn bedmaking, morning care, including a bed bath, care of the hair, mouth and teeth, back rub, care of pressure points, how to make bed rests out of boxes, use of bed tables and cradles, the giving of medicine, the treatment of communicable diseases and emergencies in the home, artificial respiration, facts about food, guides to healthful living, signs of illness, the care of babies. The course will also emphasize those aspects of home care regarded as pertinent to "survival" and the individual's desire to be of service to the community in any form of major disaster.

News of Red Cross, Vol. 9, No. 7.

* * *

Books cannot always please, however good; minds are not always craving for their food.

— CRABBE

CONVENTION HIGHLIGHTS

31st Biennial Meeting
Queen Elizabeth Theatre, Vancouver,
June 24-29, 1962.

Sunday — June 24

Registration — Queen Elizabeth Theatre
Church Services 7:30 P.M.
Protestant — St. Andrews Wesley United Church, Burrard Street
Roman Catholic — Holy Rosary Cathedral, Dunsmuir Street

Morning Monday — June 25

Miss Helen M. Carpenter, President of the CNA, Chairman
Invocation 10 A.M.
Addresses of Welcome Hon. W. A. Cecil Bennett LL.D. Premier
of British Columbia. His Worship,
Thomas Alsbury, Mayor of Vancouver.

Keynote Address

Afternoon

The Presidential Address.....Miss Helen Carpenter
International Council of Nurses.....Miss Helen Nussbaum,
General Secretary
Reports of the Executive Director, CNA.....Miss M. Pearl Stiver

Tuesday — June 26

“Nursing Values in a Changing Society”

Planned by Committees on Nursing Education and Nursing Service.

Morning

Developments in Nursing Service.....Miss Mary Richmond, Chairman

Afternoon

Developments in Nursing Education.....Miss Hazel Keeler, Chairman
Speakers and a panel discussion

Evening

Variety show, courtesy of Registered Nurses' Association of British Columbia.

Wednesday — June 27

Morning

“Common Goals of Health Services”

Panel — Doctor, Nurse, etc.

Free Afternoon

B.C. nurses are making arrangements regarding tours. See May issue for details.

Morning

Thursday — June 28

President and Committee Chairmen present reports

Afternoon

Survival Planning—A lecture demonstration...Major General A. E. Wrinch,
C.B.E., C.D., Director Sur-
vival, Department of National
Defence.

Symposium — Casualty Problems in Nuclear War

Morning

Friday — June 30

“The Voice of Nurses Was Heard in the Land”

Miss Katherine MacLaggan and Nursing Affairs Committee

Business Meeting, including resolutions

Afternoon

Special program for the conferring of Honorary Memberships

Installation of Officers

Address of the new President

Closing address — by an outstanding speaker

Special luncheons are being planned for interest groups.

(Continued from page 347)

Amy (Friend) Parke (Hamilton General Hospital '96) died recently.

* * *

Catherine Pridmore (Lady Stanley Institute, Ottawa '14) died during January 1962.

* * *

Isabel Reid (St. Joseph's Hospital, Hamilton '32) died early in 1961. She had engaged in private nursing in Hamilton, Toronto and Montreal.

* * *

Annie T. Scadding (Toronto General Hospital '07) died recently. She was 84 years of age. Miss Scadding was a supervisor in the Private Patients' Pavilion, T.G.H. for 23 years.

* * *

Sister Elizabeth Gravelle (Hôtel Dieu Hospital, Kingston '14) died suddenly during 1961. She served for many years in Kingston and latterly was on the staff of Hôtel Dieu Hospital, St. Catharines, Ont.

* * *

Sister Victoria Morton (Hôtel Dieu Hospital, Kingston) died after a short illness. She had served her hospital in various capacities for over 62 years.

* * *

Winnifred Maud (Nicholson) Scrivener (St. Joseph's Hospital, Victoria '24) died in Victoria early this year.

MEMORIAL SCHOLARSHIP FUND

In memory of MARGARET OLIVIA COGSWELL who died on August 22, 1961, a fund has been established by her many friends to provide a scholarship annually to a member of the AARN who plans further study in nursing education at the University of Alberta. Miss Cogswell had been extremely interested in this particular field of nursing. It is felt that the scholarship will be a lasting and worthy tribute to this outstanding member of our profession.

All donations may be forwarded to the fund in care of the Alberta Association of Registered Nurses, 10256 - 112 Street, Edmonton. Receipts for income tax purposes will be issued.

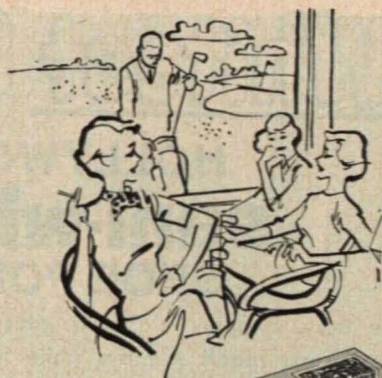
Due attention to the inside of books, and due contempt for the outside, is the proper relation between a man of sense and his books.

— CHESTERFIELD

* * *

Success has many fathers. Failure is an orphan.

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WANTED — INFORMATION

A history of the McGill School for Graduate Nurses is now being prepared for publication. Photographs, documents, reminiscences or any other pertinent information of the early years of the School are being collected, and all contributions would be gratefully received. Please label "School History" and send to:

McGILL SCHOOL FOR GRADUATE NURSES
1266 PINE AVE., MONTREAL 25, P.Q.

(Continued from page 314)

rang again. "Come quickly, my friend has collapsed!" This time it was a young person who had stayed up two nights and a day, choked on a drink, and lost consciousness. We wrapped her warmly and put hot water bottles around her, but when she woke up she had lost her voice. Tears streamed down her cheeks when she tried to talk. I stuck my neck out and said I thought it was a muscle spasm from over-tiredness, after making sure that she was not under a doctor's care for epilepsy or some other ailment. She refused to have the doctor called. We gave her a hot cup of tea, tucked her into bed and I came home — to lie awake and wonder if I had done the right thing, but I'll bet *she* slept! All was well the next day. Her voice was back to normal.

A little later a friend called to say that her daughter-in-law has such a

bad leg that she could not walk on it. It was purplish, but she had not hit it. Could they rub it with liniment? Of course, I said "Don't rub! It may be phlebitis. Go to a doctor!" I was getting a little frantic by this time, wondering if they would take my advice in reverse as Mother Noakes had done!

The bright spot in my nursing career is Mrs. Course, an elderly lady whom I had been helping before the Home Nursing Service came into effect. She has had liver and iron injections regularly over the last 10 years. I know her well. She welcomes me with a cup of strong coffee, and always sends me away with good wishes and gifts — the first asparagus of the season, a jar of wonderful black currant jam, or a small bottle of plum chutney. She makes me feel important in the scheme of things!

It's good to be back in the swing!

Experience is the name everyone gives to their mistakes.

— OSCAR WILDE



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The Canadian Nurses' Association has not reviewed the personnel policies of the hospitals and agencies advertising in the Journal. For authentic information, prospective applicants should apply to the registered Nurses' Association of the Province in which they are interested in working.

Address correspondence to:

THE CANADIAN NURSE JOURNAL
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ALBERTA

Instructor of Nurses for large active treatment Mental Hospital to teach affiliate students in an 8-wk. psychiatric nursing program. Salary range \$4,140 to \$5,220 per annum, 40-hr. work wk., Civil Service holidays, sick leave & pension program. Applicants must have considerable experience in general & psychiatric nursing, experience in administration & nursing education, University diploma in supervision & teaching, post basic preparation in psychiatric nursing or an equivalent amount of experience & education. For further particulars, Apply to: Superintendent of Nurses, Provincial Mental Institute, Dept. of Public Health, P.O. Box 307, Edmonton, Alberta.

Head Nurse with postgraduate preparations in pediatrics, or preparation & experience as head nurse, for 30-bed Pediatric Department. Salary \$315 - \$355, good personnel policies. Apply: Director of Nursing, St. Michael's General Hospital, Lethbridge, Alberta.

Registered Nurses (2) for 29-bed hospital in central Alberta, Salary \$285 - \$315 depending upon experience. Separate residence provided. Please apply stating qualifications to: Mrs. A. Bardenhagen, Matron, Municipal Hospital, Eckville, Alberta.

Registered Nurses for modern 70-bed General Hospital, salary \$295-\$320 per mo., 40-hr. wk., liberal policies, yearly increments, residence available. Situated in beautiful Peace River Country, French & English population. Apply: Sister Superior, Sacred Heart Hospital, McLennan, Alberta.

Registered Nurses (2) as soon as possible until September 1962. For 20-bed General Hospital, 70-mi. northeast of Edmonton. Starting salary \$300 per mo., 40-hr. wk., room & board available \$30 per mo. Please apply to: Matron, Municipal Hospital, Smoky Lake, Alberta.

Registered Nurses (2 immediately) for 32-bed hospital, salary \$325 per mo., 40-hr. wk., 10 legal days with pay, 1½ days sick leave per mo., 21 days vacation after 1-yr., living accommodation at hospital \$35 per mo. Valuable experience available. Good boating, fishing & swimming, beautiful scenery overlooking the mighty Peace River, also skating & picture shows. Fare from any place in Canada could be advanced & need not be repaid if you stay over six (6) months. Return fare paid after 1½ years. Kindly apply giving experience & references to: Director of Nursing, Sister Priscilla Marie, St. Theresa Hospital, Fort Vermilion, Alberta.

General Duty Registered Nurses (2) after April 15th, for busy 35-bed General Hospital situated on pavement 80-mi. east of Edmonton. Gross basic salary \$295 per mo. with 8 semi-annual \$5.00 increments, salary adjustment for previous satisfactory experience, 40-hr. wk., rotating shifts, 3-wk. vacation, 10 statutory holidays per year, 12 days sick leave yearly, cumulative to 30 days, pension plan, group plans for MSI & Blue Cross, Alberta registration or eligibility for same required. Apply: Matron Superintendent, Viking Municipal Hospital, Viking, Alberta.

General Duty Registered Nurses for 44-bed active treatment hospital. Salary \$325 per mo. with bi-yearly increments of \$5.00 each, 40-hr. wk., R & B \$40 per mo. in new residence, attractive holiday & sick leave benefits, medical & hospitalization coverage. Apply: P.O. Box 339, Spirit River, Alberta.

General Duty Graduate Nurses for active 76-bed hospital, near Calgary & Edmonton, \$285-\$335 gross salary for Alberta registered, \$275-\$325 gross salary for non-registered in Alberta. Excellent personnel policies & working conditions. Apply to: Matron, Municipal Hospital, Brooks, Alberta.

NURSES fully qualified for 30-bed active treatment hospital. New hospital building & recently renovated nurses' residence. Unless definitely interested in coming, please do not apply. Personnel policies sent upon request. Apply to: Mrs. M. Hislop, Superintendent, Municipal Hospital, Bassano, Alberta.

Nurses (2) for Health Unit. Public Health training an advantage. Salary \$3,600 - \$4,536, according to experience & qualifications with annual increment, 5-day wk., car & uniform provided. Apply to: Medical Officer of Health or Secretary-Treasurer, Box 69, Peace River, Alberta.

BRITISH COLUMBIA

Director of Nursing for 40-bed hospital at Merritt, B.C. Construction of new hospital will commence August 1962. Please apply by letter giving full details of training, experience, qualifications & salary required, to: Administrator, Nicola Valley General Hospital, P.O. Box 129, Merritt, British Columbia.

Director of Nurses for modern, active 17-bed hospital to commence duty June 1st. Salary \$375 to \$425 dependent upon experience. RNABC policies in effect. Full board in own suite provided for \$40 per mo. Applicant must have or be eligible for B.C. Registration. For further details write to: Mrs. M. Penn, Director of Nurses, General Hospital, Tofno, British Columbia.

Nursing Supervisor B.C. Registered for new hospital at Golden, British Columbia, picturesque village in the beautiful Canadian Rockies, on C.P.R. & Trans-Canada Highway, 170-miles west of Calgary, Alberta. Please indicate qualifications & salary expected. Full information regarding duties & hospital operation & organization available on request. Apply to: C. F. Collins, Administrator, Golden & District General Hospital, P.Q. Box 230, Golden, British Columbia.

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Information on these and other I.N.H.S. positions is available from Indian and Northern Health Services, Department of National Health and Welfare, in Vancouver, Edmonton, Regina, Winnipeg, Ottawa and Quebec, or from the

Director, Personnel Services,

DEPARTMENT OF NATIONAL HEALTH AND WELFARE, OTTAWA

Supervisor for Operating Room & Recovery Room for 83-bed children's hospital, charge duties to commence September 1, 1962 with an orientation period from May 1, 1962 (in the capacity of a general staff nurse). For further information write: The Director of Nursing, Children's Hospital, 250 West 59 Avenue, Vancouver 16, British Columbia.

Operating Room, Royal Jubilee Hospital, Victoria, British Columbia, positions available — 1. Clinical Instructor — Basic salary \$327 per mo. — 2. General Duty — Basic salary \$312 per mo., 4 annual increments, salary recognition for satisfactory previous experience of 2 or more years, & for postgraduate preparation. Excellent personnel policies. British Columbia registration required. Apply: Director of Nursing, Royal Jubilee Hospital, Victoria, British Columbia.

General Duty Nurses for small active hospital. Salary \$282 for unregistered Nurses in B.C. \$297 registered with yearly increments. Nurses' home available. For further particulars write: The Administrator, Lady Minto Hospital, Ashcroft, British Columbia.

General Duty Nurses for active small hospital on the Sunshine Coast, 50-mi. from Vancouver. Salary \$297-\$357, superannuation, health plan, private room in comfortable residence \$15 per mo. For further information write: The Administrator, St. Mary's Hospital, Garden Bay, British Columbia.

General Duty Nurses for 200-bed General Hospital with School of Nursing. Salary range \$297 to \$359. Pre-planned shift rotation, B.C. registration essential, 4-wk vacation after 1-yr. Apply: Director of Nursing, Royal Inland Hospital, Kamloops, British Columbia.

General Duty Nurses for new 82-bed hospital in the Aluminum City of Northern B.C. Salary RNABC recommendation plus \$15 per mo., 40-hr. wk., 9 statutory holidays, 1½ days sick leave per month accumulative to 60 days. Residence with board \$50 per mo., superannuation & 50% medical care plan paid. Increments for experience & postgraduate certificate. Apply to: Director of Nursing, General Hospital, Kitimat, British Columbia.

General Duty Nurses for 110-bed hospital in northwestern B.C. Salary—non-registered \$297, B.C. registered \$312-\$374. Travel allowance, newly furnished residence available. For full details contact: Director of Nursing, General Hospital, Prince Rupert, British Columbia.

General Duty Nurses for well-equipped 80-bed General Hospital in beautiful inland valley adjacent Lake Kathryn & Hudson Bay Gacier. Initial salary \$312, maintenance \$47.50, 40-hr. 5 day wk., 4-wk. vacation. Boating, fishing, swimming, golfing, curling, skating, skiing. Comfortable nurses' residence, rail fare advanced if necessary. Apply: Sacred Heart Hospital, Smithers, British Columbia.

General Duty Nurses for new 50-bed hospital. Salary \$297 for B.C. Registered Nurses plus \$15 northern living allowance. Situated in attractive central British Columbia town with many attractions, e.g. swimming, boating, curling, bowling. Accommodation available in new nurses' residence — \$50 per mo. to include board. Apply: Director of Nursing, Terrace & District Hospital, Box 1297, Terrace, British Columbia.

General Duty Nurses (2) required in June for 17-bed hospital on West Coast of Vancouver Island. Salaries according to RNABC agreements, RNABC personnel policies in effect. Room & board in modern nurses' residence \$40. Apply by mail or telephone to: Matron, General Hospital, Tofino, British Columbia.

General Duty Nurses starting salary \$311 if 2 years experience, \$297 to \$359 in four years, non-registered \$282. Maintenance \$50. 10 statutory holidays, 4-wk. annual vacation, 1½ days sick leave monthly. Very active town, world famous Cariboo Cattle country, annual stampede. Marriages reason for vacancies. New hospital opening in 1962. Apply: Director of Nurses, War Memorial Hospital, Williams Lake, British Columbia.

General Duty Nurses, Operating Room Nurses (with postgraduate or equivalent) in very active 146-bed General Hospital. Personnel policies in accordance with RNABC. Rooms available in nurses' residence. Apply: Director of Nursing, General Hospital, Chilliwack, British Columbia.

General Duty & Operating Room Nurses for 434-bed hospital with training school; 40-hr. wk., statutory holidays, Salary \$297-\$359. Credit for past experience & postgraduate preparation; annual increments; cumulative sick leave; 28-days annual vacation. B.C. registration required. Apply: Director of Nursing, Royal Columbian Hospital, New Westminster, British Columbia.

Graduate Nurses for 70-bed acute General Hospital on Pacific Coast. Salary for B.C. Reg'd. Nurses \$297 with regular increases; Unreg'd., \$285. Board & room \$25 per mo., 5-day wk., 28 days vacation plus 10 statutory holidays, after 1 year. Apply: Director of Nursing, St. George's Hospital, Alert Bay, British Columbia.

Graduate Nurses for 60-bed modern hospital in resort area on Vancouver Island. R.N. basic \$297 with yearly increments according to RNABC personnel policies. Enquiries: Director of Nursing, Campbell River & District General Hospital, Campbell River, British Columbia.

Graduate Nurse for 31-bed hospital, salary \$302 per mo. with annual increments, 40-hr. wk., 4-wk. vacation, 1½ day sick leave per mo. Lodging \$11 per mo. Travel from Vancouver refunded after 6 months. Application to: Administrator, General Hospital, Ocean Falls, British Columbia.

Graduate Nurses for 20-bed hospital, 35-mi. from Vancouver, on Coast. Salary & personnel practices in accord with RNABC. Bus & train transportation, accommodation available. Apply: Director of Nursing, General Hospital, Squamish, British Columbia.

Graduate Nurses (2) for General Duty in small hospital, salary \$297 per mo., 10 paid statutory holidays, 28-day vacation after 1-yr. service, room, board & laundry \$40 per mo., superannuation & sick leave benefits. Apply, giving full particulars, to: Administrator, Slocan Community Hospital, New Denver, British Columbia.

Nurses (2) by June 1st, 1962) for 30-bed hospital. Salaries as per B.C. Registered Nurses' agreement. Comfortable nurses' home. Apply to: Miss H. Campbell, R.N., Director of Nursing, Community Hospital, Grand Forks, British Columbia.

Nurses (2) for United Church Mission Hospital in northern B.C. Salary: \$305 per mo. also **Trained Practical Nurses (2)** salary \$210 per mo. An opportunity for Christian service. Apply: Winch Memorial Hospital, Hazelton, British Columbia or Dr. M. C. Macdonald, Board of Home Missions, United Church, 85 St. Clair Ave. East, Toronto, Ontario.

MANITOBA

Clinical Instructors in Medical Nursing, out-patient dept. nursing, operating room nursing, pediatric nursing, nursing arts, diet therapy, obstetrical nursing, & a **Clinical co-ordinator** required for the Fall, 1962 concurrent teaching program, for modern 700-bed hospital, enrollment 270 students. Apply: Director, St. Boniface General Hospital School of Nursing, St. Boniface 6, Manitoba.

NEW BRUNSWICK

Medical Laboratory Technician (1) General Duty Nurses (2) for modern 22-bed hospital situated near Fundy Park, 40-hr. wk., excellent personnel policies, annual 3-wk. vacation. Apply to: Mrs. E. R. Hopper, Superintendent, County Hospital, Albert, New Brunswick.

NEWFOUNDLAND

Registered Nurses for General Duty for 100-bed hospital. Government scale salary plus \$150 bonus every 6-mo., one-way transportation paid, 2-wk. vacation, 8 statutory holidays. Apply to: Nurse-in-charge, Notre Dame Bay Memorial Hospital, Twillingate, Newfoundland.

NORTHWEST TERRITORIES

DIRECTOR OF NURSING for 44-bed hospital in prosperous northern mining town. Hospital well equipped & adequately staffed. Expect to be ready for accreditation in the near future. Further information on request. Please send complete details of training & experience to: Administrator, Stanton Yellowknife Hospital, Yellowknife, Northwest Territories.



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General Duty Nurses for modern 35-bed hospital situated on beautiful South Shore. Good personnel policies. Excellent living quarters. Apply Superintendent, Fishermen's Memorial Hospital, Lunenburg, Nova Scotia.

General Duty Nurses for modern 21-bed General Hospital on scenic Eastern Shore. Nova Scotia salary scale, 3-wk. annual vacation, sick leave, pension plan & 8 statutory holidays, good personnel policies, residence accommodations. Apply, giving name of training school, date of graduation & record of employment & experience to: Superintendent, Eastern Shore Memorial Hospital, Sheet Harbour, Nova Scotia.

Operating Room Nurse for 45-bed General Hospital situated in the beautiful Annapolis Valley of Nova Scotia. Good personnel policies & salary. Apply to: The Director of Nursing, Western Kings Memorial Hospital, Berwick, Nova Scotia.

ONTARIO

Assistant Director of Nursing Service, with postgraduate preparation. Good salary & personnel policies. Apply to: Director of Nursing, St. Joseph's Hospital, Chatham, Ontario.

Supervisor of Nurses minimum salary \$5,000, car allowance, pension plan, & other benefits. Direct inquiries, including qualifications, to: Dr. I. T. Loudon, Medical Officer of Health, Norfolk County Health Unit, Box 247, Simcoe, Ontario.

Operating Room Instructor for school of nursing of The Hospital for Sick Children, Toronto, Ontario. For personnel policies & further information apply to: Director of Nursing, The Hospital for Sick Children, Toronto, Ontario.

Assistant Operating Room Supervisor for 325-bed General Hospital, modern well-equipped unit, postgraduate experience desirable, attractive personnel policies. Apply to: Director of Nursing, The Doctors Hospital, 45 Brunswick Avenue, Toronto 4, Ontario.

Assistant Superintendent of Nursing for modern 52-bed hospital. Salary commensurate with experience & qualifications. Residence accommodation available, operating room experience essential. Apply to: Superintendent, General Hospital, Kincardine, Ontario.

Obstetrical Clinical Instructor, good personnel policies. Apply: Director of Nursing, Belleville General Hospital, Belleville, Ontario.

Operating Room Charge-Nurse for new 30-bed hospital, starting salary \$300 per mo. Good working conditions. Apply: District Hospital, Shelburne, Ontario.

Head Nurses, General Duty Nurses & Certified Nursing Assistants for new 85-bed hospital with modern equipment, situated in a progressive town of 5,000, located 23-mi. from London, Ontario. Postgraduate education preferred, excellent personnel policies, salary commensurate with experience & qualifications, opportunity for advancement. Apply: Director of Nursing, Strathroy Middlesex General Hospital, Strathroy, Ontario.

Registered Nurses for expanding General Hospital, Medical, Surgical, Operating Room & Obstetrical services, at Ajax, Ontario on Highway 401, 20 mi. east of Toronto, hourly bus service to hospital. Salary in accordance with qualifications & experience, increments every 6 mo., sick & vacation time after 6 mo., sick time cumulative to 14 days, 37½-hr. work wk., pension plan, living-in accommodation. Apply to: Director of Nursing, Ajax & Pickering General Hospital, Ajax, Ontario. **Nurses from Europe & United Kingdom**, apply to: Canadian Department of Labor, 61 Green Street, London, W.1, England.

Registered Nurses for 100-bed General Hospital. Salary range \$320 - \$360 per mo., 3-wk. vacation, paid sick leave, pension plan in effect, accommodation in nurses' residence if desired, room & board \$50 per mo. For particulars apply: Director of Nurses, Lady Minto Hospital, Cochrane, Ontario.

Registered Nurses for 34-bed hospital, min. salary \$320, 3-wk. vacation with pay, sick leave after 6-mo. service. **Certified Nurses Assistants** salary \$220, 2-wk. vacation with pay. **All staff** — 5-day 40-hr. wk., 9 statutory holidays, pension plan & other benefits. Apply to: Superintendent, Englehart & District Hospital, Englehart, Ontario.

Registered Nurses for smaller sized hospital. Rotating shifts, good personnel policies. Apply: Superintendent, Kemptville District Hospital, Kemptville, Ontario.

Registered Nurses for new 52-bed hospital. Salary \$285-\$300 per mo., Excellent personnel policies. OHSC, P.S.I. & Pension Plan in operation. Apply stating training, experience & age to: Superintendent, Centre Grey General Hospital, Markdale, Ontario.

Registered Nurses eligible for Ontario registration, for General Duty in 29-bed hospital near Timmins. Gross salary \$320 per mo. with annual increments to \$360. 40-hr. wk., usual fringe benefits. Living accommodation in nurses' residence at \$45 per mo. Apply to: Superintendent, Bingham Memorial Hospital, Matheson, Ontario.

Registered Nurses for new 55-bed hospital, located in the center of a summer vacationland. Minimum salary \$305. For personnel policies & further information write to: The Director of Nursing, Prince Edward County Memorial Hospital, Picton, Ontario.

Registered Nurse (full time) for new 30-bed hospital, salary commencing at \$265 per mo., good working conditions. Apply: District Hospital, Shelburne, Ontario.

Registered Nurses for 60-bed hospital, starting salary \$300 gross per mo., good personnel policies. Apply: Superintendent, St. Marys Memorial Hospital, St. Marys, Ontario.

Registered Nurses & Certified Nursing Assistants for modern 75-bed hospital. Starting salaries — R.N.'S \$310 per mo., C.N.A.'S \$220 per mo. Single room accommodation available in the residence. Dryden (population 6,500) an industrial town, also center of extreme tourist area, is conveniently located midway between Winnipeg & the Canadian Lakehead. For further information regarding personnel policies, community activities, etc. please call or write: The Director of Nursing, Dryden District General Hospital, Dryden, Ontario.

Registered Nurses & Certified Nursing Assistants for 95-bed General Hospital in attractive town on Lake Huron in a vacation resort area. Salary — Registered Nurse — \$280 gross per mo. plus recognition for experience & regular increments. C.N.A.'s — \$195 per mo. and regular increments. Usual benefits pension plan, paid sick time, etc. residence accommodation available. Apply to: Director of Nursing, Alexandra Marine & General Hospital, Goderich, Ontario.

Registered Nurses & Certified Nursing Assistants for 160-bed accredited hospital. Starting salary \$320 & \$220 respectively with regular annual increments for both. Excellent personnel policies including 5-day wk. Hospital of Ontario pension plan. Residence accommodation available. Assistance with transportation can be arranged. Apply: Director of Nurses, Kirkland & District Hospital, Kirkland Lake, Ontario.

Registered Nurses & Certified Nursing Assistants for 26-bed hospital. R.N. minimum salary \$320, maximum \$370, 28-day vacation after 1 yr. C.N.A. minimum salary \$232, maximum \$265, 2-wk. vacation after 1 yr., 3-wk. after 2yr. Credit for past experience, \$5.00 increment every 6 mo., 40-hr. wk. 8 statutory holidays. Room & board \$45 per mo., 1-day sick leave per mo. Apply to: Mrs. G. Gordon, Superintendent, District Memorial Hospital, Box 37, Nipigon, Ontario.

Registered Nurses for General Duty for 28-bed General Hospital, located in mining & resort area, basic salary \$300 - \$315 per mo., 6 monthly increments, 4-wk. vacation after 1-yr. Residence accommodation \$30 per mo. For further particulars apply to: Miss J. Scollie, Matron, Margaret Cochenour Memorial Hospital, Cochenour, Ontario.

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Miss Jean O'Brien Butler, Director of Nursing

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Registered Nurses for General Duty in all departments including premature & new-born nursery, Isolation, Emergency & Recovery Room. Good salary & personnel policies. Apply: Director of Nursing, Victoria Hospital, London, Ontario.

Registered Nurses for General Duty (Permanent or Summer Relief Staff) for modern 40-bed hospital in resort town on beautiful Lake Huron. Starting gross salary \$300, 40-hr. wk., 10 working days sick leave in 1 year, 50% unused sick leave paid at end of year. 50% single OHSC & PSI premium paid, 8 statutory holidays, 4-wk. vacation after 1 yr, board & room \$30, modern living quarters. Apply: Superintendent, Saugeen Memorial Hospital, Southampton, Ontario.

Registered Nurses for General Duty & Operating Room in modern hospital (opened in 1956). Situated in the Nickel Capital of the world, pop. 80,000 people. Salary: \$395 per mo. with annual merit increments, plus annual bonus plan, 40-hr. wk. Recognition for experience. Good personnel policies. Assistance with transportation can be arranged. Apply: Director of Nursing, Memorial Hospital, Sudbury, Ontario.

Registered Nurses for General Duty in modern 18-bed Private Hospital in iron mining town, 140 mi. north of Sault Ste. Marie, Ontario. Starting salary \$290 min. to \$330 max. for experience, less \$20 per mo. for maintenance. Excellent accommodations & personnel policies, transportation allowance after 6-mo. service. **Operating Room Nurse** starting salary \$310 min. with postgraduate course. \$350 max. with 3-yr. experience or more. Apply: Superintendent of Nurses, Miss O. Keswick, Lady Dunn Hospital, Wawa, Ontario.

Registered Nurses for General Duty Staff for 106-bed General Hospital. Salary \$295 plus \$5.00 raises after 6-mo., 1 year, 1½ years, 2 years, 3 years & \$10 after 5th year to maximum of \$330 per mo. Evening differential \$10 per mo. with night differential \$5.00 per mo. Apply to: Director of Nursing, Norfolk General Hospital, Simcoe, Ontario.

Registered General Duty Nurses (Immediately) for all departments in new 259-bed hospital located in Niagara Peninsula. Starting salary \$305 with 3 annual increments to \$335 per mo., 5-day 40-hr. wk. with 3-wk. annual vacation, pension plan, etc. Residence accommodation available. Apply to: Director of Nursing, County General Hospital, Welland, Ontario.

Registered Staff Nurses for case room & operating room for 325-bed General Hospital located in central area of city. Rotating hours of duty; attractive personnel policies. Apply to: Director of Nursing, The Doctors Hospital, 45 Brunswick Avenue, Toronto 4, Ontario.

Registered Nurses for Staff Duty & Operating Rooms in General Hospital. All patients' services in new modern building opened in November 1960. Good salary & personnel policies. Apply to: Director of Nursing, Arnprior & District Memorial Hospital, Arnprior, Ontario.

General Duty Nurses Male & Female & Certified Nursing Assistants (Immediately) for 86-bed hospital, 40-hr. wk., 8 statutory holidays & other employee benefits. Collingwood is situated on Georgian Bay & is noted as a vacationland with 7-mi. sand beach and great skiing on the Blue Mountains in winter. For further information apply: Director of Nursing Services, General & Marine Hospital, Collingwood, Ontario.

General Duty Nurses for an accredited 66-bed hospital. Starting salary: \$305. Excellent personnel policies, pension plan, residence accommodation only 10 min. from downtown Buffalo. Apply: Director of Nursing, Douglas Memorial Hospital, Fort Erie, Ontario.

General Duty Nurses for modern 100-bed hospital. Registered start at \$300 monthly. Graduates \$250 - \$285; 40-hr. wk., benefits include accident, sickness & life insurance, hospital & medical insurance plans, & O.H.A. Pension Plan. **Male Nurse**, graduate or registered also needed. Apply: Miss Tillett, Director of Nursing, Leamington District Memorial Hospital, Leamington, Ontario.

General Duty Nurses for 100-bed hospital, up-to-date facilities in a beautiful location on the shore of Lake Erie. Salary \$285 per mo. with recognition for P.G. courses, 40-hr. wk. Residence available. Apply: Director of Nursing, General Hospital, Port Colborne, Ontario.

General Duty Nurses for 100-bed modern hospital, south western Ontario, 32 mi. from London. Salary commensurate with experience & ability; \$285 gross. Residence accommodation available. Pension plan. Apply giving full particulars to: The Director of Nurses, District Memorial Hospital, Tillsonburg, Ontario.

General Duty Nurses (2) for 21-bed United Church Mission Hospital on the west coast of B.C. Salary \$297 non-registered & \$307 registered. Apply to: General Hospital, Queen Charlotte City, or Dr. M. C. Macdonald, Secretary, Board of Home Missions, 85 St. Clair Avenue E., Toronto, Ontario.

Operating Room Nurses for general operating room work which includes cardiovascular, neurosurgery, genito-urinary, ear, eye, nose & throat & orthopedic surgery. Good salary & personnel policies. Apply: Director of Nursing, Victoria Hospital, London, Ontario.

Public Health Nurses (Qualified) for a generalized program in an urban-rural area. Personnel policies & further information on request. Apply to: The Director of Nursing, Simcoe County Health Unit, Court House, Barrie, Ontario.

Public Health Nurses (qualified) Salary \$3,700 to \$4,700, annual increment \$200, car provided or car allowance. Apply to: Dr. Charlotte M. Horner, Director, Northumberland-Durham Health Unit, Box 337, Cobourg, Ontario.

Public Health Nurses required by Stormont, Dundas & Glengarry Health Unit for generalized program in Seaway Development Area, usual benefits, liberal car allowance, pension plan, allowance for experience. Apply to: Dr. Paul S. deGrosbois, Medical Officer of Health, Health Unit, 26 Pitt Street, Cornwall, Ontario.

Public Health Nurse (qualified) salary \$3,650 - \$4,400 - (under revision), allowance for experience, 5-day wk., 4-wk. vacation, car allowance, sick leave credits, employer shared P.S.I., O.H.S. & pension plan. Apply to: Mr. A. F. Stewart, Secretary-Treasurer, Wentworth County Health Unit, Court House, Hamilton, Ontario.

Public Health Nurse for Kitchener Department of Health, starting May 1962. For further information write to: Miss Olga Friesen, Department of Health, 233 Queen Street South, Kitchener, Ontario.

Public Health Nurses (qualified) for generalized program in a highly urbanized & rural area, salary \$3,900 to \$4,650. For further information apply to: Dr. A. F. Bull, Medical Officer of Health, Halton County Health Unit, Milton, Ontario.

Public Health Nurses - Minimum salary \$3,800, allowance for experience up to the maximum of \$4,750. Car allowance, pension plan, & other benefits. Personnel policies on request. Apply to: Dr. J. M. McGarry, M.O.H., St. Catharines-Lincoln Health Unit, St. Catharines, Ontario.

Public Health Nurses minimum salary \$3,900, car allowance, pension plan, & other benefits. Direct inquiries, including qualifications, to: Dr. I. T. Loudon, Medical Officer of Health, Norfolk County Health Unit, Box 247, Simcoe, Ontario.

Public Health Nurse for Sudbury & District Health Unit. Salary scale \$3,800 - \$5,000, allowance for P.H.N. experience, Uniform allowance, liberal fringe benefits. For information, Apply to: Dr. J. B. Cook, Director, 50 Cedar Street, Sudbury, Ontario.

Public Health Nurses for generalized program, salary range \$3,700 - \$4,500 (minimum based on experience). Good personnel policies, 3-wk. vacation, accumulative sick leave, pension plan & other benefits. Apply to: Dr. J. Howie, Director, Metropolitan Windsor Health Unit, 2090 Wyandotte Street East, Windsor, Ontario.

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Appointments to nursing positions are available.

Good personnel policies in effect including medical welfare plan, 40 hour week — four weeks vacation. In-Staff Education program well established during winter months.

Salary \$297 - \$359 per month
with consideration for experience or special preparation.

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GENERAL
HOSPITAL
MONTREAL
QUE.**



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In this modern 400-bed non-sectarian hospital in Administration, Teaching, Staff Nursing.

- Certified Nursing Assistants also required.
- Openings in all Clinical Services • Excellent personnel policies • Bursaries for post-basic courses in Teaching and Administration.

For further information, please write:

DIRECTOR OF NURSING, JEWISH GENERAL HOSPITAL, 3755 COTE ST. CATHERINE ROAD, MONTREAL, QUE.

BERMUDA

Registered Nurses. Excellent opportunities in **Private Nursing** are available in Bermuda. Rates similar to those in effect in Province of Quebec. For information regarding openings write to Matron, King Edward VII Memorial Hospital, Bermuda.

Registered Nurses for General Duty Staff. Salary commences at \$50-0-0 per mo. with full maintenance. Transportation allowance. For full particulars apply Matron, King Edward VII Memorial Hospital, Bermuda.

Registered Nurses for Operating Room with operating room postgraduate course and/or experience, for 140-bed hospital. Travel allowance paid. For particulars, write: Matron, King Edward VII Memorial Hospital, Bermuda.

QUEBEC

Assistant Head Nurses; excellent personnel policies. Apply Director, Shriners' Hospital for Crippled Children, 1529 Cedar Avenue, Montreal, Quebec.

Registered Nurses for 30-bed General Hospital, 50 mi. from centre of Montreal, excellent bus service. Starting salary \$300 per mo., salary increases as recommended by ANPQ, 40-hr. wk. 4-wk. annual vacation, statutory holidays, 2-wk. sick leave, Blue Cross paid, living accommodation available. Apply: Mrs. D. Hawley, R.N., County Hospital, Huntingdon, Quebec.

Registered Nurses & non-registered graduates from another province or country for Chronic Hospital. Salaries as per ANPQ. Appointments by telephone or write: Mrs. L. Wright, R.N., 7745 Sherbrooke Street East, Montreal 5, Quebec.

SASKATCHEWAN

Obstetric Supervisor responsible for supervision of 25-bed unit, & clinical instruction of students. Also **Nursing Arts Instructor, & Medical-Surgical Clinical Instructor**, new 185-bed General Hospital opening March, 1962. School of Nursing — 61 students. Apply: Director of Nursing, Yorkton Union Hospital, Yorkton, Saskatchewan.

Registered Nurses (2) for new completely modern 27-bed hospital. Initial salary \$290 per mo., 40-hr. wk., excellent working conditions & living accommodation, new modern residence. Apply to: Superintendent of Nursing Services, Kipling Memorial Union Hospital, Kipling, Saskatchewan.

Registered Nurses (2 immediately) for Union Hospital, Mossbank, with Dr. J. E. Miller in attendance. Salaries as per SRNA with increments & benefits. 40-hr. wk., fully modern nurses' residence, daily bus service to the city, recreational opportunities. Apply to: Fred Howlett, Hospital Sec., Mossbank, Saskatchewan.

Registered Nurses for General Duty for modern company hospital. Salary \$315 - \$360, additional allowance for postgraduate work, 21 - 35 day vacation, good personnel policies, group insurance, recreational facilities, plus free maintenance & comfortable living accommodation, transportation paid from point of hire. Apply to: Miss N. Prefontaine, R.N., Supervisor, Gunnar Hospital, Gunnar, Saskatchewan.

U.S.A.

Registered Nurses for modern 374-bed JCAH fully accredited General Hospital. Located on beautiful San Francisco Peninsula, 20-min. drive from the heart of the city. Openings in all services. Excellent personnel policies. Many extra benefits & opportunities for advancement. Top salaries. Apply: Personnel Director, Peninsula Hospital, 1783 El Camino Real, Burlingame, California.

Registered Nurses Career satisfaction, interest & professional growth unlimited in modern, JCAH accredited 254-bed hospital. Located in one of California's finest areas, recreational, educational & cultural advantages are yours as well as wonderful year-round climate. If this combination is what you're looking for, contact us now! **Staff Nurse** entrance salary \$360 with automatic increases to \$420 per mo., supervisory positions at increased rate. Special area & shift differentials paid. Excellent benefits including Blue Cross hospitalization & surgical coverage & liberal personnel policies. Professional staff appointments available in all clinical areas to those eligible for California licensure. Write today: Director of Nursing, Eden Hospital, 20103 Lake Chabot Road, Castro Valley, California.

Registered Nurses (Come to sunny California) Staff Nurses for permanent positions, various departments, days, evens, nights. Excellent starting salary, increments, benefits & working conditions in one of the largest & finest general hospitals in the West. For details write: Personnel Department, Queen of Angels Hospital, 2301 Bellevue Avenue, Los Angeles 26, California.

Registered Nurses: Expansion has created excellent opportunities for the new employee who wishes to progress in the field of nursing, our 525-bed General Hospital offers experience in all occupational specialties including psychiatric nursing. Starting salaries, **General Duty** \$390 per mo. days; \$415 per mo. P.M. & nights; \$10 differential per mo. for psychiatry; **Operating Room** \$415 per mo. days; \$440 P.M. & nights. Its location, in the heart of California, affords a pleasant climate & easy access to all summer & winter recreational activities. Liberal employment benefits, including pd. holidays, paid vacation, paid sick leave, free hospitalization insurance, retirement plan, etc., Write: Personnel Dept., Sutter Community Hospitals, 2820 — L Streets, Sacramento, California.

Registered Nurses for private 258-bed hospital for men, women & children. Staff Nurse salaries from \$355 - \$435, differentials for evenings, nights, communicable disease, operating room & delivery. Opportunities in all clinical areas. Holidays, vacations, sick leave & health insurance. California registration required. Applications & details furnished on request. Contact: Personnel Director, Children's Hospital, 3700 California Street, San Francisco 18, California.

Registered Nurses General Duty for 230-bed approved teaching hospital, resort city. Starting salary \$350 plus \$22.50 shift differential, provision for housing allowance. Apply: Director of Nursing, Cottage Hospital, Santa Barbara, California.

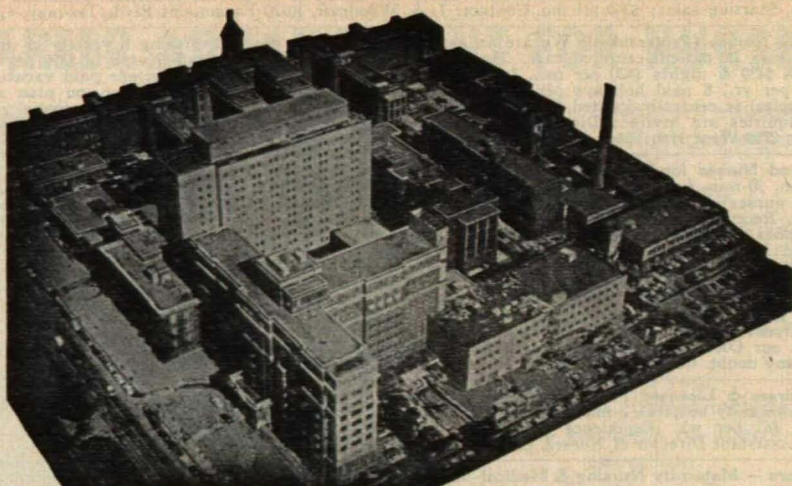
Registered Nurses & Licensed Practical Nurses for hospital with new wing to open in May. Total capacity of 365-beds. Need nurses for medical-surgical, obstetrics, recovery room & emergency room. Starting salary for days: \$355 per mo. with \$25 differential for evenings & nights. Regular raises. Practical Nurses starting salary is \$260 per mo. Good personnel policies. For further information write to: Director of Nursing Service, St. Mary's Hospital, 509 E. 10th. Street, Long Beach, California.

Staff Nurses for new modern 800-bed General & Tuberculosis Institution in beautiful San Joaquin Valley city — no smog — no snow — 235,000 in metro. area, midway between Los Angeles & San Francisco, close to 3 National Parks, 2 colleges & other cultural advantages. Full maintenance available. Immediate appointment. \$4,320 to \$5,400 per year. Apply immediately to: Director of Personnel, Fresno County Civil Service, Room 101, Hall of Records Building, Fresno 21, California.

Staff Nurses for 150-bed General Hospital in California's famed San Joaquin Valley. Salary to \$415 per mo. plus top fringe benefits. Limited living quarters available. California license required. Smaller community (15,000) with excellent recreational facilities nearby, offers pleasing change from urban congestion, traffic, etc. Apply: Personnel Office, County of Madera, Courthouse Annex, Madera, California.

Staff Nurses for 300-bed General Hospital. Attractive personnel policies plus differential for specialties, afternoon & night duty. Opportunities for advanced education. Apply to: Director of Nursing Service, Kaiser Foundation Hospital, Oakland 11, California.

Staff Duty positions in private 428-bed hospital, non-registered graduates acceptable. Liberal personnel policies & salary. Write to: Personnel Director, Hospital of the Good Samaritan, 1212 Shatto Street, Los Angeles 17, California.



TORONTO GENERAL HOSPITAL

REQUIRES

**Registered Nurses and Certified Nursing Assistants
for Medical and Surgical Services
including newly opened Neurosurgical and Cardiovascular Units
Rewarding Experience — Excellent Personnel Policies**

For information write to:

Director of Nursing, Toronto General Hospital, 101 College Street, Toronto 2, Ontario

GENERAL DUTY NURSES FOR ALL DEPARTMENTS

Gross salary \$320 monthly with annual increments for 3 years to \$350.

Until registration in Ontario is established — \$295.

Rotating periods of duty — 40 hour week, 8 statutory holidays annually — Annual vacation 21 days after one year.

Annual sick time 12 days after one year, cumulative to 18 days.
Hospitals of Ontario Pension Plan.

Ontario Hospital Insurance and Physicians' Services Incorporated,
50% payment by hospital.

Apply:

DIRECTOR OF NURSING, GENERAL HOSPITAL, OSHAWA, ONTARIO.

Office Nurses (eligible for California registration) for group of 20 private practice Specialists near Los Angeles, Starting salary \$360 per mo. Contact: J. A. Woodruff, 10720 Paramount Blvd., Downey, California.

Graduate Nurses (Professional) We are an established teaching hospital offering a variety of interesting assignments in patient-centered care. The current starting salary for Staff Nurse is \$390 per mo., for evenings \$430 & nights \$420 per mo., for a 40-hr, 5-day wk. Fringe benefits include paid vacation up to 4 wks. per yr., 8 paid holidays per year, cumulative sick leave, Blue Cross & pension plan available. The hospital is centrally located & offers private room accommodations in our modern nurses' residence. Your inquiries are invited: Director of Nursing Service, Department C.J.N., Mount Sinai Hospital of Chicago, 2750 West 15th Place, Chicago 8, Illinois.

Registered Nurses for 200-bed General Hospital located in beautiful suburban residential area on Lake Michigan, 30-min. from Chicago. Base salary \$380, differential of \$20 for nights, \$30 for evenings. Live in modern nurses' bungalows adjacent to hospital & enjoy social, cultural & educational advantages of Chicago. Recent completion of new building creates opportunities in all clinical services, liberal personnel benefits include free retirement program. Contact: Director of Nursing, Highland Park Hospital, Highland Park, Illinois.

Operating Room Nurses for modern 200-bed General Hospital along the shores of Lake Michigan, 30-min. from Chicago. Progressive salaries and policies. Live in modern nurses' bungalows adjacent to hospital & enjoy social, cultural & educational advantages of Chicago, 6-room brand new operating suite, utilizing most current "nurse saving" methods & equipment. If you're a confirmed OR nurse you'll be right at home in our OR! If you feel you might be interested in OR (but aren't sure) our OR will convert you, beyond any doubt. Contact: Director of Nursing, Highland Park Hospital, Highland Park, Illinois.

Staff Nurses & Licensed Practical Nurses (Openings in several areas, all shifts.) 37½-hr. work wk., in small community hospital, 2-mi. from Boston. Living quarters available. Minimum starting pay \$73 R.N.'s; L.P.N.'s \$61 per wk. Experience considered, differentials for reliefs, nights. Contact: Miss Elizabeth Hewitt, Assistant Director of Nurses, Chelsea Memorial Hospital, Chelsea, Massachusetts.

Instructors — Maternity Nursing & Medical-Surgical Nursing for diploma program based upon an academic year, NLN accreditation, 160 students. Modern 240-bed hospital, JCAH accredited. Minimum qualifications B.S. in nursing education or satisfactory equivalent. Salary commensurate with qualifications. Excellent personnel policies. Write: Director, School of Nursing, Abbott Hospital, 110 E. 18th Street, Minneapolis, Minnesota.

Staff Nurses 380 bed hosp. new 120 med-surg. unit. Trans. pd. 1st class air to Albuquerque, and return within U.S. in exchange for 1-yr. emp. contract. Come to New Mexico "Land of Enchantment." Career opportunities, largest pvt. JCAH accredited hosp. in state; near U. of New Mexico, R.N. & B.S. pgm. Practical Nurse pgm. accredited state & NAPNE. Vacancies, Med-Surg. & occasionally O.B., Peds. & O.R., salaries \$315 per mo. even., night or O.R. with call; 6-mo. increases up to \$375; days \$300 per mo. with increases up to \$360. Rotation from day duty is required only when no person desiring permanent P.M. of night tour is available. Liberal personnel policies include: optional Blue Cross, Discount Hosp. Services, pd. sick leave cumulative to 5 wks., annual physical exam., vacation 1 yr. — 2 wks., 2 yrs. — 3 wks. 5 yrs. — 4 wks. Active inservice pgm. Occasional vacancy hosp. owned apts. New Mexico licensure as professional nurse & U.S. Citizenship (or Immigration Visa) required. Write or call collect: Mrs. Emily J. Tuttle, Dir. of Nursing, Presbyterian Hospital Center, 1012 Gold, S.E., Albuquerque, New Mexico. Phone 243-5611.

Courses FOR R.N.'S N.Y. POLYCLINIC MED. SCH. & HOSP. — in heart of Manhattan — 6-mo. courses in: O.R. NURSING OPD. NURSING, MED.-SURG. NURSING. Classes 4 times yearly: Mar., June, Sept., Dec. Room, meals, Medical Care & monthly cash stipend. Positions available to graduates of our Courses. For information write: Director of Nursing Education, 345 W. 50 St., N.Y.C., NEW YORK.

Graduates Nurses for 450-bed non-sectarian acute General Hospital with NLN fully accredited school of nursing. Liberal personnel policies include tuition aid for study at Western Reserve University. Opening of new main building has created attractive positions for Staff Nurses in medical, surgical, obstetric & pediatric divisions. Apartments available in immediate neighborhood. Apply: Miss Louise Harrison, Director of Nursing Service, Mount Sinai Hospital, 1800 East 105th. Street, Cleveland 6, Ohio.

Staff Nurses: Exchange Visitor program offers opportunities to learn & earn at large modern tuberculosis hospital in convenient suburban Cleveland, Ohio. Start at \$344 per mo. with semi-annual increments. 5-day work wk., paid vacation & 6 holidays, liberal sick leave, board, room & laundry at low rate in pleasant accommodations in nurses' home. Increase your professional experience at a progressive accredited hospital in an expanding community. Write: Director of Nursing, Sunny Acres Hospital, Cleveland 22, Ohio.

Registered Nurse (Scenic Oregon, vacation playground, skiing, swimming, boating & cultural events) for 295-bed teaching unit on campus of University of Oregon medical school. Salary starts at \$372. Pay differential for nights & evenings. Liberal policy for advancement, vacations, sick leave, holidays. Apply: Multnomah Hospital, Portland 1, Oregon.

Staff Nurses (All Clinical Services) Base salary \$319, differential for 3-11 and 11-7 shifts, liberal personnel policies include sick leave, retirement plan, 3-wks. vacation & laundry of uniforms. Orientation & in-service programs — housing available on campus or in vicinity of hospitals. Apply: Director of Nursing Service, The University of Texas-Medical Branch Hospitals, Galveston, Texas.

Operating Room Supervisor for JCAH 200-bed General Hospital, complete modern facilities, department well established, advance preparation & experience required. Excellent personnel policies & starting salary with regular advances & merit increases. Wonderful community — 50,000. State capital with growing medical center of Wyoming. Contact: Administrator, Memorial Hospital, Cheyenne, Wyoming.

ONTARIO

Assistant Director of Nursing for 106-bed General Hospital with planned expansion. Please apply stating experience & qualifications to: Director of Nursing, Norfolk General Hospital, Simcoe, Ontario.

Public Health Nurses required by Oxford Health Unit for generalized program. Car allowance, pension plan & other benefits, personnel policies on request. Apply to: Supervisor of Public Health Nursing, Oxford Health Unit, Woodstock, Ontario.

Staff Nurses for 350-bed General Hospital located in downtown Toronto, rotating hours of duty, attractive personnel policies, planned orientation & in-service education program. Apply to: Director of Nursing, The Doctors Hospital, 45 Brunswick Avenue, Toronto 4, Ontario.

U.S.A.

General Duty Staff Nurses for 450-bed fully approved hospital. Salary range per mo., day duty \$419-\$438; P.M. & night duty \$429-\$448, 40-hr. wk., excellent personnel policies, registration or permit to work in California required. Address applications to: Chief Nurse, Southern Pacific Railroad Hospital, San Francisco 17, California.

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Nurses with advanced education for leadership are needed urgently throughout Canada.

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Assumption University of Windsor offers special opportunities for

REGISTERED NURSES

1. Bachelor of Science in Nursing — two years
 2. Diploma — one year
- Professional courses include special emphasis on liberal education.

Residence Facilities — Gymnasium
— Pool — Counselling Services

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ESSEX COLLEGE
Assumption University
of Windsor,
Windsor, Ontario.**

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**250-bed General Acute Hospital, Centrally located in
SAN FRANCISCO, CALIFORNIA**

IMMEDIATE day, evening and night positions available for nurses in:

**SURGERY, CARDIAC AND INTENSIVE CARE,
GENERAL STAFF DUTY**

Qualified applicants guaranteed positions for visa purposes.

SALARY RANGE from \$365-\$435 plus \$36.50 P.M. shift (3 - 11:30 P.M.) and specialty differentials, medical benefits and liberal holiday and vacation benefits.

GRADUATE medical resident program with University of California Medical School in General Surgical, Neurological, Ortho, and Plastic Surgery.

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Modern General Hospital, located in the Garden City of Canada, adjacent to American Cities and close to Toronto and Hamilton.

Good salary, 40 hour week with half-yearly increments — participation in Hospitalization, Pension, and Group Life Insurance — three weeks' vacation and Statutory Holidays.

Copy of Personnel Policy available on request.

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HOTEL DIEU HOSPITAL
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Positions available for qualified Public Health Nurses in various centres in British Columbia. **SALARY — \$356 - \$440** per month; car provided. An opportunity for interesting and challenging professional service in this beautiful and fast-developing Province. For further information and application forms, apply to The Director, Public Health Nursing, Department of Health Services and Hospital Insurance, Parliament Buildings, VICTORIA, B.C., or to The Chairman, B.C. Civil Service Commission, 544 Michigan Street, VICTORIA, B.C. **COMPETITION NO.62:57.**

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FOR 35-BED HOSPITAL

Salary \$305 with annual increments, allowance for experience and postgraduate training, 40 hour week — 9 statutory holidays, 3 week vacation after one year — 4 weeks thereafter, 1 day sick leave per month accumulative, generous fringe benefits, nurses' residence—board \$45 per month.

Apply: **LITTLE LONG LAC HOSPITAL, GERALDTON, ONTARIO.**

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FOR 42-BED GENERAL HOSPITAL

Salary \$295 with six months increments. Allowance for past experience. Generous fringe benefits. Board and residence \$45 per month.

On paved highway 38 miles from Winnipeg. New construction program well advanced.

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NURSING CONSULTANT (Mental Health) \$7,500-\$8,700

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To act as the Senior Nursing Consultant in Psychiatry. A Baccalaureate degree in nursing and at least ten years of acceptable experience is required.

For further details and application forms write immediately to the **CIVIL SERVICE COMMISSION, OTTAWA.**

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REGISTERED NURSES

AND

CERTIFIED NURSING ASSISTANTS

Are invited to enquire re: employment opportunities for all departments of new 140-bed hospital. Good personnel policies, O.H.A. Pension Plan.

Enquire:

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ONE CLASS PER YEAR

Well-equipped modern school
100-bed hospital. Fully accredited,
40 miles east of Edmonton.

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THE DIRECTOR OF NURSING
ARCHER MEMORIAL HOSPITAL
LAMONT, ALBERTA

MANITOBA REHABILITATION HOSPITAL

requires

GENERAL STAFF NURSES
on and after May 1st, 1962

For information, write to:
DIRECTOR OF NURSING
MANITOBA REHABILITATION HOSPITAL
800 SHERBROOKE STREET
WINNIPEG 2, MANITOBA

CANORA UNION HOSPITAL CANORA, SASK.

requires 4

REGISTERED NURSES for GENERAL DUTY
75-bed General Hospital

Starting salary \$290 with differential for experience and postgraduate training.

Residence accommodation if desired.

Apply to:

THE DIRECTOR OF NURSING
CANORA UNION HOSPITAL, CANORA, SASK.

REGISTERED NURSES

For modern 50-bed hospital located in an English speaking community in the Province of Quebec. Prominent resort area, modern new nurses' residence, beautifully furnished, 40-hour week and statutory holidays, three weeks leave after one year's service, \$270 per month plus night duty differential of \$20 per month. Room and board \$25 per month.

Apply:

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PONTIAC COMMUNITY HOSPITAL
SHAWVILLE, QUEBEC



Operating Room Nurses

\$75 to \$100

Day duty. 10-week orientation program. Regular rotation on all services. Staff includes surgical technicians. On call and emergency coverage twice per month. Scheduled surgery Monday through Friday.

Opportunity for advancement to supervisory and teaching positions, if qualified by experience and education.

Your inquiries will be welcomed by
MISS ELLEN ADAMS, Personnel Director

NEW ENGLAND
DEACONESS HOSPITAL

185 Pilgrim Road

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NURSING INSTRUCTOR

(BILINGUAL)

\$5,160 - \$5,880

required by
DEPARTMENT OF VETERANS AFFAIRS
ST. ANNE'S HOSPITAL

STE ANNE DE BELLEVUE, P.Q.

Candidates must be graduates of an approved school of nursing and possess current registration in a province of Canada, and a certificate in Teaching and Supervision. In addition, candidates must possess at least five years of acceptable experience, some of which shall have been in a teaching or supervisory capacity.

For further details and application forms, write to:

CIVIL SERVICE COMMISSION, OTTAWA.
Please ask for Information Circular 62-466.

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required by

St. Joseph's Hospital, Guelph, Ontario

Before August 27th, 1962

Salary commensurate with preparation and experience

Liberal personnel policies

Apply giving full particulars to:

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GUELPH, ONTARIO

THE SCHOOL OF NURSING
BROCKVILLE GENERAL HOSPITAL, BROCKVILLE, ONT.

Invites applications for — Instructor

Requirements: University preparation in Nursing Education

Salary differential for degree

Apply to:

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HOTEL DIEU ST. JOSEPH HOSPITAL
BATHURST, N.B.

requires

General Duty Nurses — for all departments.

For further information apply to:

**DIRECTOR OF NURSING, HOTEL DIEU ST. JOSEPH,
BATHURST, NEW BRUNSWICK.**



**PROVINCE
OF ALBERTA**

**The Provincial Mental Hospital
Ponoka, Alberta.**

EMPLOYMENT OPPORTUNITIES

(A) General Duty Nurses — Preference given to nurses with experience in Psychiatric Nursing.

Salary — \$280 to \$375 per month, depending on qualifications and experience.

(B) Instructors (Classroom and Clinical) to teach:

1. Basic Course in General and Psychiatric Nursing

2. Affiliate Program in Psychiatric Nursing

3. Post Basic Course in Psychiatric Nursing

Salary — \$315 to \$495 per month, depending on qualifications and experience.

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-
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-
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INDEX TO ADVERTISERS

APRIL, 1962

COMMERCIAL

Abbott Laboratories Ltd.	291	Investors Syndicate	355
Alconox Ltd.	302	Lakeside Laboratories (Canada)	
Arlington-Funk Laboratories 332,	333	Ltd.	287
C. R. Bard	304	Thos. Leeming & Co. Inc.	281
Bland & Co.	289, 290	Lewis-Howe Co.	302
Blistex Inc.	289	J. B. Lippincott Co.	Cover IV
Canadian Tampax Corp. Ltd. .	296	C. V. Mosby Co.	292
Cash's Names	290	Nivea Pharmaceuticals Ltd.	293
Four Season Travel	353	Parke Davis & Co. Ltd. ...	Cover III
Charles E. Frosst & Co.	294	Resinol Chemical Co.	302
G. T. Fulford & Co. Inc.	303	Robson Leather Ltd.	285
H. J. Heinz Co. of Canada Ltd. .	298	The Ryerson Press	288
Holland-Rantos Co. Inc.	301	W. B. Saunders Co.	299
Hollywood Sani-White Shoe		Sterling Name Tape Co.	300
Polish	354	Swift Canadian Co. Ltd.	295
Homemakers' Products (Canada)		United Surgical Supplies Co. Inc.	300
Ltd.	384	White Sister Uniform Inc.	
Ted Hoyer & Co. Inc.	290		Cover II
Imperial Tobacco Co. of Canada		Winthrop Laboratories of Canada	
Ltd.	353	Ltd.	297

PROFESSIONAL

Alberta	356	Montreal Neurological Institute .	382
Assumption University of		New Brunswick	358
Windsor	367	Newfoundland	358
Bermuda	364	Northwest Territories	358
British Columbia	356	Notre Dame Hospital	382
Children's Hospital of		Nova Scotia	360
Washington, D.C.	381	Nova Scotia Sanatorium	382
Dalhousie University	378	Ontario	360
Extension Course in Nursing Unit		Oshawa General Hospital	365
Administration	381	Quebec	364
Franklin Hospital — California .	367	Royal Victoria Hospital	380
Hartford Hospital	359	Saskatchewan	364
Indian & Northern Health		Toronto General Hospital	365
Services	357	U.S.A.	364
Jewish General Hospital	363	University of British Columbia .	378
McMaster University	381	University of Montreal	379
Maimonides Hospital of Brooklyn	361	University of New Brunswick ..	379
Manitoba	358	University of Saskatchewan	378
Massachusetts Eye and Ear		Vancouver General Hospital	363
Infirmiry. Boston	381	Wills Eye Hospital —	
Mental Health Services		Philadelphia	380
British Columbia	381	Winnipeg General Hospital	380

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*Niedelman, M. L. and Bleier, A.; Jour. Ped., 37:5, 762, Nov. 1950
Fischer, C. C. and Lipschutz, A.; Am. Jour. Dis. Child, 89:5, 596, May 1955
Benson, R. A., et al: Arch. Ped., 73:250 - 8, July 1956

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